Health and Welfare Fund

Teamsters Local Union No. 856

1000 Marina Blvd Ste 400 • Brisbane CA 94005-1841 • Phone (800) 297-4595
2323 Eastlake Ave E • Seattle WA 98102-3305 • Phone (800) 297-4595

IMPORTANT INFORMATION FOR ANTHEM HMO PLAN PARTICIPANTS

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April 2019

MEMORANDUM

TO: Actives and Retirees enrolled in the Anthem HMO Plan –
Teamsters Local Union No. 856 Health and Welfare Trust Fund

FROM: Board of Trustees

RE: Direct Pay Medical Plan - ***Exclusive Provider Option (EPO)*** (Using the Anthem Blue Cross Network) replacing the Anthem Blue Cross HMO, Effective July 1, 2019

The Trustees of the Teamsters Local Union No. 856 Health and Welfare Trust Fund have made some important changes to your Health and Welfare benefit plan.

Recently, members enrolled in the Anthem HMO have experienced uncertainty in their provider network. Certain members were told by Anthem that they were required to change primary care physicians, only later told that the network was restored. In addition, the Trust Fund has experienced rapidly increasing premiums for the Anthem HMO Plan. In order to maintain benefit levels in the most cost-effective manner and expand provider availability, the Trust Fund will be replacing the Anthem Blue Cross HMO Plan with an Exclusive Provider Option Direct Pay Medical Plan.

Beginning with coverage effective July 1, 2019, the Welfare Fund will offer a Direct Pay Exclusive Provider Option (EPO) as a medical plan option. This Exclusive Provider Option (EPO) Medical Plan is only available to employees and retirees who were enrolled in the Anthem Blue Cross HMO Program as of June 30, 2019. The Board of Trustees will monitor the experience of this new EPO Plan and may expand eligibility for participation at a future date. Please review the enclosed material that describes the benefits available under the EPO plan. **The benefits under the EPO plan have been designed to be as similar as possible to the Anthem HMO plan**. The network of providers available in the Anthem HMO is also available under the Direct Pay EPO. The Board of Trustees has contracted with Anthem Blue Cross for the purpose of making their expansive Prudent Buyer Network of preferred providers available to employees and their eligible dependents who are covered under the Direct Pay Medical Plan EPO Plan. **The Prescription Drug benefit that has been a part of the Anthem HMO benefits will be now be administered by OptumRx.**

Effective with coverage ending June 30, 2019, the Trust Fund has terminated their agreement with Anthem HMO and will no longer be offering the Anthem HMO as a benefit option. If any member of your family is currently enrolled in the Anthem HMO, they must change health plans. You may select Kaiser HMO, the Direct Pay PPO Medical Plan or the Direct Pay EPO Medical Plan.

If you are currently enrolled in the Anthem HMO, you will be automatically switched to the Direct Pay EPO Medical Plan. If you wish to change your enrollment effective July 1, 2019 to the Kaiser HMO or the Direct Pay PPO Plan, you must complete the enclosed enrollment material and return it to the Fund Office by June 10, 2019 for July 1, 2019 coverage. Whichever Plan you enroll, you will receive a new Medical Plan ID card and a separate Rx Benefit ID card shortly before the effective date of July 1, 2019.

The Anthem Blue Cross PPO is called the Prudent Buyer Network**.** Therefore, whenever you see the term Prudent Buyer just remember it is the Anthem Blue Cross network of providers. The Direct Pay Exclusive Provider Option (EPO) is called the Exclusive Plan Option (EPO) because, with limited exceptions, the Plan will only pay benefits from providers that are part of the Anthem Blue Cross Prudent Buyer PPO network. Except for a few services, such as emergency services, benefits are not payable to providers that are not part of the network.

Non-emergency out of network claims will receive no reimbursement whatsoever under the EPO Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under the EPO Plan. The only exception to the foregoing exclusion is for out of network emergency care.

To receive benefits under the Exclusive Plan Option (EPO) Direct Pay Medical Plan, it is imperative that you make certain you are using a Prudent Buyer provider for all hospital and doctor services. You can locate an Anthem PPO provider which is referenced as "Blue Cross PPO" within the website site (see below steps for locating a provider).

It is your responsibility to verify current Prudent Buyer status of the provider before you obtain services. You will receive an identification card, which identifies you as being eligible to use the Anthem Blue Cross Prudent Buyer network of Preferred Providers. Remember to ask your doctor if he/she is an Anthem Blue Cross Prudent Buyer Preferred Provider.

Anthem Blue Cross Website
Participating health care providers in the Prudent Buyer network include hospitals, physicians, and laboratory and radiology facilities. From time to time providers are added or deleted from the network. To find a provider, simply go to the Anthem Blue Cross web site and use the online provider finder resource.

Follow these easy steps to find a participating California provider:

- Go to ***http://www.anthem.com/ca***
- Click on continue after each one of these steps

1. Select Providers then Find a Doctor

2. Plan Information – select Large Group Plans

3. Plan Information – select your coverage: Blue Cross PPO

4. Type of Provider – select a provider type (e.g., health facility, physician, specialist, etc.)

5. Specialty (optional) – you may select a specialty to refine your search. To select multiple specialties, hold down the control key and click on each specialty name.

6. Location or Name – enter location or name criteria. Receive your search results via a listing, map or downloadable directory.

If you have any question about these changes, please contact the Fund Administrator at (800) 297-4595.

RK:fg

DIRECT PAY MEDICAL PLAN BENEFITS

Exclusive Provider Option (EPO) Plan

(For Active Employees and Non-Medicare Retirees/Dependents of Retirees)

For benefits effective July 1, 2019 this Exclusive Provider Option (EPO) Direct Pay Medical Plan is only available to employees and retirees who were enrolled in the Anthem Blue Cross HMO Program as of June 30, 2019. The Anthem Blue Cross HMO contract has been terminated. This section applies only to employees who are enrolled in the Exclusive Provider Option (EPO) Direct Pay Medical Plan. If you are enrolled in the Direct Pay PPO Option, your benefits are described in another section of the Summary Plan Description. If you are enrolled in the Kaiser medical plan, a separate Evidence of Coverage is available which describe those benefits.

Introduction

The Board of Trustees has contracted with Anthem Blue Cross for the purpose of making their expansive Prudent Buyer Network of preferred providers available to employees and their eligible dependents who are covered under the Direct Pay Medical Plan.

Anthem Blue Cross has established a network of "Preferred Providers." These providers have agreed to participate in the Anthem Blue Cross preferred provider organization program, called PPO for short.

The Anthem Blue Cross PPO is called the Prudent Buyer Plan**.** Therefore, whenever you see the term Prudent Buyer just remember it is the Anthem Blue Cross PPO. This Plan is called the Exclusive Plan Option (EPO) because, with limited exceptions, the Plan will only pay benefits from providers that are part of the Anthem Blue Cross Prudent Buyer PPO network. Except for a few services, such as emergency services, benefits are not payable to providers that are not part of the network.

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

To receive benefits under the Exclusive Plan Option (EPO) Direct Pay Medical Plan, it is imperative that you make certain you are using a Prudent Buyer provider for all hospital and doctor services.

When you think of a PPO, you probably think of doctors and hospitals, which is correct. However, there are other health care providers, which are neither physicians nor hospitals. The Anthem Blue Cross Prudent Buyer Network includes an expanded list of providers in addition to doctors and hospitals. For example, ambulatory surgical centers, home health care agencies, home infusion therapy providers, skilled nursing facilities and medical products and services.

These Prudent Buyer preferred providers have agreed to provide health care for covered persons and accept the Plan's payment for a covered service plus the covered person's share of the covered charge (i.e. co-insurance, co-payment, penalty amount [if any]) as payment in full.

It is your responsibility to verify current Prudent Buyer status of the provider before you obtain services. Remember to ask your doctor if he/she is an Anthem Blue Cross Prudent Buyer Preferred Provider. You can also locate Prudent Buyer doctors online at ***www.anthem.com/ca*** or by calling the Fund Office.

You will receive an identification card, which identifies you as being eligible to use the Anthem Blue Cross Prudent Buyer network of Preferred Providers. To be eligible for coverage you must work the required hours and be eligible for benefits as explained in the Eligibility section (Article II of the Rules and Regulations).

Anthem Blue Cross Website

Participating health care providers in the Prudent Buyer network include hospitals, physicians, and laboratory and radiology facilities. From time to time providers are added or deleted from the network.

There is a quick and easy way to find participating Prudent Buyer health care providers – including doctors and hospitals. To find a provider, simply go to the Anthem Blue Cross web site and use the online provider finder resource.

Follow these easy steps to find a participating California provider:

- Go to ***http://www.anthem.com/ca***

- Click on continue after each one of these steps

    1. Select Providers then Find a Doctor

    2. Plan Information – select Large Group Plans

    3. Plan Information – select your coverage: Blue Cross PPO

    4. Type of Provider – select a provider type (e.g., health facility, physician, specialist, etc.)

    5. Specialty (optional) – you may select a specialty to refine your search. To select multiple specialties, hold down the control key and click on each specialty name.

    6. Location or Name – enter location or name criteria. Receive your search results via a listing, map or downloadable directory.

Alternately to the above, you can:

- Inquire of a physician or other provider if he/she is an Anthem Blue Cross Prudent Buyer Provider.

- Contact the Fund Office at (800) 297-4595. Remember, **it is your responsibility** to make certain that you are receiving medical services from a Prudent Buyer provider.

Prior Authorization Review and Approval Program

Inpatient Admissions

All non-emergency in-patient admissions to a hospital, skilled nursing facility or approved treatment facility must be approved (prior authorization) by Anthem Blue Cross **BEFORE** you are admitted. In the event of a medical emergency (requiring surgery or inpatient admission), you must notify Anthem Blue Cross within 48 hours of being admitted as an inpatient or as soon thereafter as possible.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care.

The inpatient admissions approval program applies to the following:

- Pre-service review determines the medical necessity of scheduled non-emergency admission.

- Concurrent review determines whether services continue to be medically necessary and appropriate when pre-service review is not required or has been performed as required.

- Retrospective review is performed when Anthem Blue Cross has not been notified and therefore has been unable to perform the appropriate pre-service or concurrent review.

Failure to obtain a prior authorization for an inpatient admission will result in a decrease of hospital room and board covered benefits. This amount is an out-of-pocket expense and may not be applied toward the medical deductible or out-of-pocket maximum.

Also, Anthem Blue Cross will perform a retrospective review of the inpatient stay and no Plan benefits will be provided for any inpatient days which are determined to not be medically necessary.

Other Services
In addition to review for all inpatient services, prior approval by Anthem Blue Cross is required for certain other services. If prior approval is not obtained for the following services, benefits may be denied in whole or in part based on a retrospective medical review giving consideration to medical necessity and that the charges incurred are for a covered service:

- Transplants
- Home health care
- Hospice care
- Home infusion therapy
- Potentially cosmetic/investigative services
- Certain durable medical equipment or prosthetics

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee your eligibility for coverage. Eligibility and benefits are based on the date you receive the services. An approval does not guarantee payment or that you will receive the highest level of benefits. For example, services not listed as covered, services received after you lose eligibility under the Plan and services that are not medically necessary will be denied.

Contact Anthem Blue Cross at (800) 274-7767 for all prior authorization reviews.

Your Benefits for the Teamsters Local 856 Health and Welfare EPO Plan

It's important to remember:

- The benefits of this *plan* are given only for those services that the Group finds are *medically necessary*.
- Care must be received from your *primary care doctor* or another *Anthem Blue Cross Prudent Buyer PPO Provider* to be a covered service under this *plan*. If you do not use an *Anthem Blue Cross Prudent Buyer PPO provider*, your entire claim will be denied unless:
  - The services are for *emergency* or out-of-area *urgent care*;
- Just because a *doctor* orders a service, it doesn't mean that:
  - The service is *medically necessary*; or
  - This *plan* covers it.
- If you have any questions about what services are covered, read this booklet, or give us a call at the number on your Member ID card.
- All benefits are subject to coordination with benefits available under certain other plans.
- We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.
- The Teamsters Local Union 856 Health and Welfare Trust Fund has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking *emergency services*, out-of-area *urgent care* services in accordance with this *plan* from non-*Anthem Blue Cross Prudent Buyer PPO provider* could be balanced billed by the non-*Anthem Blue Cross Prudent Buyer PPO provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

What are Copays?

A *copay* is a set amount you pay for each medical service. You need to pay a *copay* for some services given under this *plan*, but many other supplies and services do not need a *copay*. Usually, you must pay the *copay* at the time you get the services. The *copays* you need to pay for services are shown in the next section.

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for emergency out of network care.

Here are the Copay Limits

If you pay more than the *Copay Limits* shown below in one calendar year (January through December), you won't need to pay any more *copays* for the rest of the year.

Per Number of Members	Copay Limits
One *Member*	**$2,000**
Family Members	**$3,000***

* But, not more than **$2,000** for any one *Member* in a Family. For any given family member, the *Copay Limit* is met either after he/she meets the amount for *Member*, or after the entire family *Copay Limit* is met. The family *Copay Limit* can be met by any combination of amounts from any family member.

- For *infertility*, any *copay* for diagnosis and testing for finding out about it.

What We Cover

We list benefits for the services and supplies in this section. Any *copays* you must pay are shown next to the service or supply. We list things **we do NOT cover in the next section**.

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

COVERED SERVICES	COPAY
Doctor Care (or services of a Health Professional)	
Office visits for a covered illness, injury or health problem	$15
Home visits, when approved, at the *doctor's* discretion	$15
Injectable or infused medications[1] given by the *doctor* in the office	20% with a maximum copay of $150
Surgery in *hospital, surgery center* or *medical group* and surgical assistants	No charge
Anesthesia services	No charge
Doctor visits during a *hospital stay*	No charge
Visit to a *specialist*	$15
Preventive Care Services Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means preventive care services are covered with no deductible (if applicable) or copay when you use an *Anthem Blue Cross Prudent Buyer PPO provider*.	
Full physical exams and periodic check-ups ordered by your *primary care doctor* including well-woman visits	No charge
Vision or hearing screenings[2]	No charge
Immunizations prescribed by your *primary care doctor*	No charge
Health education programs given by your *primary care doctor*	No charge

[1] This does not include immunizations prescribed by your *primary care doctor* nor allergy serums.

[2] Vision screening includes a vision check by your *primary care doctor* to see if it is *medically necessary* for you to have a complete vision exam by a vision *specialist*. If OK'd by your *primary care doctor*, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.

COVERED SERVICES	COPAY
Health screenings as prescribed by your *doctor* or *health care provider* Health screenings include mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.[1]	No charge
Preventive services for certain high-risk populations as determined by your *doctor*, based on clinical expertise	No charge
Counseling and intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling.	No charge
HIV testing, regardless of whether testing is related to a primary diagnosis	No charge
Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: • Breast feeding support, supplies, and counseling ordered by your *primary care doctor.* One breast pump will be covered per pregnancy under this benefit. • Gestational diabetes screening. • Preventive prenatal care. • Screening for iron deficiency anemia in pregnant women. • Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation.	No charge
Diabetes	
Equipment and supplies used for the treatment of diabetes (see below) • Blood glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips. • Insulin pumps • Pen delivery systems for insulin administration (non- disposable). • Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.	See "Medical Equipment"
Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications	See "Prosthetic Devices"
Diabetes education program services supervised by a *doctor* which include: • Teaching you and your family members about the disease process and how to take care of it; and • Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.	$15

[1] This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

COVERED SERVICES	COPAY
General Medical Care (In a Non-Hospital-Based Facility)	
Hemodialysis treatment, including treatment at home if approved	$15
Medical social services	No charge
Chemotherapy	No charge
Radiation therapy	No charge
Infusion therapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN)	$15
Allergy tests and care	$15
X-ray and laboratory tests:	
• *Advanced imaging procedures*	No charge per test
• Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn or BRCA testing)	No charge
• All other x-ray and laboratory tests	No charge
Smoking cessation programs for nicotine dependency	No charge
Pregnancy or Maternity Care Medical services for an enrolled *member* are provided for pregnancy and maternity care, including the following services: Prenatal, postnatal, and postpartum care, ambulatory care services (including ultrasounds, fetal non-stress tests, *doctor* office visits, and other *medically necessary* maternity services performed outside of a *hospital*), involuntary complications of pregnancy, diagnosis of genetic disorders in cases of high-risk pregnancy, and inpatient *hospital* care including labor and delivery.	
Office visit	$15
Doctor's services for normal delivery or cesarean section	No charge
Hospital services:	
• Inpatient services	No charge
• Outpatient covered services	No charge
Genetic testing, when *medically necessary*	No charge
Prenatal testing administered by the State Department of Public Health for the California Prenatal Screening Program	No charge
Hospital services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled *member*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details **Note:** For inpatient *hospital* services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her *doctor* decide on an earlier discharge.	No charge

COVERED SERVICES	COPAY
Infertility and Birth Control Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" benefit.	
Diagnosis and testing for *infertility*	50%[1]
Sterilization for females	No charge
Sterilizations for females will be covered under the "Preventive Care Services benefit. Please see that provision for further details.	
Sterilization for males	$50
Family planning services	$15
Shots and implants for birth control[2]	No charge
Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *doctor***	No charge
Doctor's services to prescribe, fit and insert an IUD or diaphragm[2]	No charge
Mastectomy	
Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema	See *copays* that apply
Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy	See *copays* that apply
Reconstructive Surgery	
Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also includes *medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. This does not apply to orthognathic surgery. Please see the "Dental Care" benefit below for a description of this coverage.	See *copays* that apply
Rehabilitative Care You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative care. The 60 day limit does not limit the number of visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, you must get an approval. It must be shown that more care is *medically necessary*. While there is no limit on the length of the covered period of care or the number of covered visits for *medically necessary* rehabilitative care, you must get an approval for the longer time period and extra visits in advance. Rehabilitative care as described above is also provided for a *member* who is being treated for a *severe mental disorder* or for pervasive developmental disorder or autism. This care is provided even though the *member* may not have suffered an illness or injury. If more than a 60-day period of care is needed, the longer time period and additional visits must be approved in advance.	

[1] **Note:** The **50%** *copay* made for *infertility* services will not be applied to the "*Copay Limits*."

[2] Certain contraceptives and related services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

COVERED SERVICES	COPAY
Visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy	$15
Inpatient Hospital Services	
A *hospital* room with two or more beds, or a private room only if *medically necessary*, ordered by your *primary care doctor* and approved Inpatient hospital services and supplies include the following: • Operating room and special treatment room; • Special care units; • Nursing care; • *Drugs* and medicines, and supplies you get during your *stay*. This includes oxygen; • Laboratory, cardiology, pathology and radiology services; • Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis; and • Blood transfusions. This includes the cost of blood, blood products or blood processing.	No charge
Outpatient (In a Hospital or Surgery Center)	
Emergency room use, supplies, other services, *drugs* and medicines. This includes oxygen	$50[1]
Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services	No charge
X-ray and laboratory tests:	
• Advanced *imaging procedures*	No charge per test
• All other x-ray and laboratory tests	No charge
Other outpatient *hospital* services and supplies, including physical therapy, occupational therapy, or speech therapy.[2]	$15
However, for the following outpatient services, your copay will be:	
• Chemotherapy	$15
• Radiation therapy	$15
• Hemodialysis treatment	$15
• Infusion therapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN)	$15
*These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, you must get an approval. (See "Rehabilitative Care" above.)	
Urgent Care *Urgent care* is not an *emergency*. It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call within 48 hours if you are admitted to a *hospital*.	
Doctor's office visit or urgent care facility use, supplies, other services, *drugs* and medicines. This includes oxygen	$15[3]

[1] You don't have to pay the **$50** if you are admitted as an inpatient.

[2] These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, your *primary care doctor* must get an approval. (See "Rehabilitative Care" above.)

[3] You don't have to pay the **$15** if you are admitted as an inpatient to a *hospital*.

COVERED SERVICES	COPAY
Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services.	No charge
Skilled Nursing Facility Services	
You can get these kinds of care in a *skilled nursing facility* for **up to 100 days in a calendar year**. Services and supplies provided by a *skilled nursing facility* • A room with two or more beds; • Special treatment rooms; • Regular nursing services; • Laboratory tests; • Physical therapy, occupational therapy, speech therapy, or respiratory therapy; • *Drugs* and medicines given during your *stay*. This includes oxygen; • Blood transfusions; and • Needed medical supplies and appliances.	No charge
Home Health Care We will cover home health care furnished by a *home health agency* (HHA*)* for **up to 100 visits in a calendar year**.	
Home health care services provided by a *home health agency* Home health care services include the following: • Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a *doctor* • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • Visits with a medical social service worker • Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less)	No charge
Medically necessary supplies from the HHA When available in your area, benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home. These services are described in the "Mental Health Conditions/Substance Abuse" section below.	No charge
Hospice Care We will cover *hospice* care services shown below for the palliative care of pain and other symptoms if you have an illness that may lead to death within one year or less. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. The *hospice* must send a written care to the Group for approval every 30 days.	
Interdisciplinary team care to develop and maintain a plan of care	No charge
Short-term inpatient *hospital* care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission	No charge
Physical therapy, occupational therapy, speech therapy and respiratory therapy	No charge
Social services and counseling services	No charge
Skilled nursing services given by or under the supervision of a registered nurse.	No charge
Certified home health aide services and homemaker services given under the supervision of a registered nurse.	No charge
Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation	No charge
Volunteer services given by trained *hospice* volunteers directed by a *hospice* staff member	No charge

COVERED SERVICES	COPAY
Drugs and medicines prescribed by a *doctor*	No charge
Medical supplies, oxygen and respiratory therapy supplies	No charge
Care which controls pain and relieves symptoms	No charge
Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family *member's* death	No charge
Dental Care	
Inpatient *hospital* services Inpatient *hospital* services are limited to 3 days when the *stay* is: • Needed for dental care because of other medical problems you may have. • Ordered by a *doctor* (M.D.) or a dentist (D.D.S. or D.M.D.) • Approved by the *Group*.	No charge
General anesthesia and facility services when dental care must be provided in an outpatient *hospital* or *surgery center* These services are covered when: • You are less than seven years old; • You are developmentally disabled; or • Your health is compromised and general anesthesia is *medically necessary*. **Note**: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	No charge
Emergency care for accidental injury to natural teeth • The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition. • This *plan* does not cover any other kind of dental care.	No charge
Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part	No charge
Medically necessary dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures	No charge
"Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.	
Transgender Services	
Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *doctor*. This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including medical necessity requirements, medical management, and exclusions for *cosmetic services*, except as specifically stated in this provision. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's prescription drug* benefits (if such benefits are included). You must obtain our approval in advance in order for transgender services to be covered.	

COVERED SERVICES	COPAY
We will also pay for certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion. This travel expense benefit is not available for non- surgical transgender services. • Ground transportation to and from the *hospital* when it is 75 miles or more from your place of residence. • Coach airfare to and from the *hospital* when it is 300 miles or more from your residence. • Lodging, limited to one room, double occupancy. • Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement. You must obtain our approval in advance in order for travel expenses to be covered.	
Transgender services	See *copays* that apply
Transgender travel expense	No charge[1]
Medical Equipment	
Medical equipment and supplies	No charge
You can get long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are: • Ordered by your *primary care doctor*. • Used only for the health problem. • Used only by the person who needs the equipment or supplies. • Made only for medical use. Equipment and supplies are **not** covered if they are: • Only for your comfort or hygiene. • For exercise. • Only for making the room or home comfortable, such as air conditioning or air filters.	
Pediatric Asthma Equipment and Supplies	
Nebulizers, including face masks and tubing	No charge
These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.	
Inhaler spacers and peak flow meters	
These items are subject to the copay for *brand name drugs*.	
Pediatric asthma education program services to help you use the items listed above	$15
Organ and Tissue Transplants	
Services and supplies are given if: • You are receiving the organ or tissue.	
Services given with an organ or tissue transplant	See *copays* that apply

[1] Our maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed).

COVERED SERVICES	COPAY
Ambulance	
Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met: For ground ambulance, you are transported: • From your home, or from the scene of an accident or medical *emergency*, to a *hospital*, • Between *hospitals*, including when you are required to move from a *hospital* that does not contract with Anthem Blue Cross to one that does, or • Between a *hospital* and a *skilled nursing facility* or other approved facility. For air or water ambulance, you are transported: • From the scene of an accident or medical *emergency* to a *hospital*, • Between hospitals, including when you are required to move from a hospital that does not contract with us to one that does, or • Between a hospital and another approved facility. Non-emergency ambulance services are subject to medical necessity reviews by your Trust Fund. *Emergency* ground ambulance services do not require pre-service review. When using an air ambulance in a non-emergency situation, your Trust Fund reserve the right to select the air ambulance provider. If you do not use the air ambulance selected in a non-emergency situation, no coverage will be provided. You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility. Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *doctor* are not a covered service. Other non-covered ambulance services include, but are not limited to, trips to: • A *doctor's* office or clinic; • A morgue or funeral home. If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.	
Your copays for covered ambulance services are:	
Base charge and mileage	No charge per trip
Disposable supplies	No charge
Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV solutions	No charge
IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN *EMERGENCY*. IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 9- 1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM. PLEASE USE THE 9-1-1 SYSTEM FOR MEDICAL EMERGENCIES ONLY.	

COVERED SERVICES	COPAY
Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach. Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such a skilled nursing facility), or if you are taken to a *doctor's* office or to your home. **Hospital to hospital transport:** If you are being transported from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need. Certain specialized services are not available at all *hospitals*. For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals*. For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *doctor* prefers a specific *hospital* or *doctor*.	
Prosthetic Devices You can get devices to take the place of missing parts of your body.	
Surgical implants (including, but not limited to, cochlear implants)	No charge
Artificial limbs or eyes	No charge
The first pair of contact lenses or eye glasses when needed after a covered and *medically necessary* eye surgery	No charge
Breast prostheses following a mastectomy	No charge
Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy	No charge
Therapeutic shoes and inserts designed to treat foot complications due to diabetes	No charge
Certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part	No charge
Colostomy supplies	No charge
Supplies needed to take care of these devices	No charge
Mental Health Conditions/Substance Abuse You can get services for the *medically necessary* treatment of *mental health conditions* and substance abuse or to prevent the deterioration of chronic conditions. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse. Before you get services for facility-based care for the treatment of mental health conditions and substance abuse, you must get our approval first.	
Inpatient *facility-based care* for the treatment of *mental health conditions* and substance abuse Inpatient services include hospital services and services from a residential treatment center (including crisis residential treatment) as stated in the "Inpatient Hospital Services" provision of this section, for inpatient services and supplies.	No charge
Inpatient *doctor* visits during a *stay* for the treatment of *mental health conditions* and substance abuse	No charge
Outpatient *facility-based care*, including *partial hospitalization programs* and *intensive outpatient programs*, for the treatment of *mental health conditions* and substance abuse	No charge

COVERED SERVICES	COPAY
Other outpatient services include multidisciplinary treatment in an intensive outpatient psychiatric treatment program, behavioral health treatment for Pervasive Developmental Disorder or autism in the home, and psychological testing.	
Office visits and *intensive in-home behavioral health services* (when available in your area), received from a *doctor* for the treatment of *mental health conditions* and substance abuse	No charge
Office visits include those for the following: • individual and group mental health evaluation and treatment, • nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, • drug therapy monitoring, • individual and group chemical dependency counseling, • medical treatment for withdrawal symptoms, • methadone maintenance treatment.	
Behavioral health treatment for pervasive developmental disorder or autism in an office Inpatient services, outpatient items and services, and office visits, are covered under this section. You must get our approval first for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan*. No benefits are payable for these services if our approval is not obtained.	No charge
Hearing Aid Services	
Covered hearing aids The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from: • an otolaryngologist; or • a state-certified audiologist. Services include: • Audiological evaluations to: – measure the extent of hearing loss; and – determine the most appropriate make and model of hearing aid. These evaluations will be covered under the *plan* benefits for office visits to *doctors*. • Hearing aids (monaural or binaural) including: – ear mold(s), the hearing aid instrument; and – batteries, cords and other ancillary equipment. • Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid. No benefits will be provided for the following: • Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss; • Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for *prosthetic devices* (see "Prosthetic Devices"). • Charges for a hearing aid which is not determined to be *medically necessary*.	No charge

COVERED SERVICES	COPAY
Chiropractic Care	
Office visit	$15[1]
You may have up to **20** visits, combined with visits for acupuncture services, in a calendar year for covered services that are determined to be *medically/clinically necessary*. Covered services include: • An initial new patient exam provided by a *chiropractor* to determine the appropriateness of chiropractic services. An initial new patient exam is only covered if the *member* seeks services from a *chiropractor* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from a *chiropractor*. You are required to pay a Copay. • Follow-up office visits, as set forth in a treatment plan approved, including manipulation of the spine, joints and/or musculoskeletal soft tissue, re- evaluation, and/or other services, in various combinations, provided by a *chiropractor*. All follow-up office visits must be *medically/clinically necessary*. You are required to pay a Copay. • An established patient exam performed by a *chiropractor* when determined to be *medically/clinically necessary* to assess the need to continue, extend or change a treatment plan already approved. An established patient exam is only covered when used to determine the appropriateness of chiropractic services. You are required to pay a Copay. • Adjunctive physiotherapy modalities and procedures, as set forth in a treatment plan that has been approved, including therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies provided by a *chiropractor*. Adjunctive physiotherapy modalities and procedures are covered only when provided during the same course of treatment, and in conjunction with, chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue. All adjunctive physiotherapy modalities and procedures must be *medically/clinically necessary* for the treatment of neuromusculoskeletal disorders and provided in conjunction with chiropractic services. If adjunctive therapy is provided separately from an office visit, you are required to pay a Copay. Your *chiropractor* is responsible for submitting a treatment plan to the Group for prior approval.	
X-rays and laboratory tests when prescribed by a *chiropractor* and approved by the Group.	No Copay
Covered services include radiological consultations when determined by the Group to be *medically/clinically necessary* and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with the Group to provide those services.	
Chiropractic appliances, up to **$50** in a calendar year, when prescribed by a *chiropractor* and approved as *medically/clinically necessary*	No Copay

[1] Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

COVERED SERVICES	COPAY
Covered chiropractic appliances are limited to: • Elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports; • cervical collars or cervical pillows; • ankle braces, knee braces, or wrist braces; • heel lifts; • hot or cold packs; • lumbar cushions; • rib belts or orthotics; and • home traction units for treatment of the cervical or lumbar regions.	
Acupuncture Services	
Office visit You may have up to **20** visits, combined with visits for chiropractic care, in a calendar year for covered services that are determined to be *medically/clinically necessary*. Covered services include: • An initial new patient exam provided by an *acupuncturist* to determine the appropriateness of acupuncture services. An initial new patient exam is only covered if the *member* seeks services from an *acupuncturist* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from an *acupuncturist*. You are required to pay a Copay. • Follow-up office visits, as set forth in a treatment plan approved, including acupuncture services and/or re-evaluation provided by an *acupuncturist*. All follow-up visits must be *medically/clinically necessary*. You are required to pay a Copay. • An established patient exam performed by an *acupuncturist* when determined to be *medically/clinically necessary* to assess the need to continue, extend or change a treatment plan already approved. An established patient exam is only covered when used to determine the appropriateness of acupuncture services. You are required to pay a Copay. • Adjunctive therapy, as set forth in a treatment plan approved, including therapies such as acupressure, cupping, moxibustion, or breathing techniques provided by an *acupuncturist*. Adjunctive therapy is covered only when provided during the same course of treatment, and in conjunction with, acupuncture. All adjunctive therapy must be *medically/clinically necessary* for the treatment of neuromusculoskeletal disorders, nausea or pain and provided in conjunction with acupuncture services. If adjunctive therapy is provided separately from an office visit, you are required to pay a Copay.	$15[1]

[1] Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

What We Do Not Cover

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

It's important for you to know that we are not able to cover all the care you may want. Some services and supplies are not covered and some have limited benefits.

Kinds of Services You Cannot Get with this Plan

- **Care Not Covered.** Services you got before you were on the *plan*, or after your coverage ended.
- **Care Not Listed.** Services not listed as being covered by this *plan*.
- **Care Not Needed.** Any services or supplies that are not *medically necessary*.
- **Incarceration.** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- **Experimental or Investigative.** Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization.
- **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.
- **Government Treatment.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this *plan's* benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving *medically necessary* health care services that are covered by this *plan*.
- **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *doctor*, except as specifically provided or arranged by us. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
- **Services Received Outside of the United States.** Services rendered by providers located outside the United States, unless the services are for *emergencies,* emergency ambulance services and *urgent care*.
- **Services Not Needing Payment.** Services you are not required to pay for or are given to you at no charge.

- **Work-Related.** Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law.

We will provide care for a work-related health problem, but we have the right to be paid back for that care.

Other Services Not Covered

- **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

- **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

- **Braces or Other Appliances or Services** for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery" and "Dental Care" under the section What We Cover.

- **Clinical Trials.** Services and supplies in connection with clinical trials.

- **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *doctor* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

- **Consultations** given using telephones, facsimile machines, or electronic mail. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Cosmetic Surgery.** Surgery or other services done to change or reshape normal parts or tissues of the body to improve appearance.

- **Custodial Care or Rest Cures.** Room and board charges for a *hospital stay* mostly for a change of scene or to make you feel good. Services given by a rest home, a home for the aged, or any place like that.

- **Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

  - Extraction, restoration, and replacement of teeth;
  - Services to improve dental clinical outcomes.

  This exclusion does not apply to the following:

  - Services which we are required by law to cover;
  - Services specified as covered in this booklet**;**
  - Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

- **Drugs Given to you by a Doctor.** The following exclusions apply to *drugs* you receive from a *doctor*:

  - **Delivery Charges.** Charges for the delivery of *prescription drugs*.

- **Food or Dietary Supplements.** Nutritional and/or dietary supplements and counseling, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Gene Therapy.** Gene therapy as well as any *drugs*, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

- **Health Club Membership.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a *doctor*. This exclusion also applies to health spas.

- **Immunizations.** Immunizations needed to travel outside the USA.

- **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

- **Infertility Treatment.** Any *infertility* treatment including artificial insemination or in vitro fertilization, and sperm banks.

- **Lifestyle Programs.** Programs to help you change how you live, like fitness clubs, or dieting programs.

- **Medical Equipment, Devices and Supplies.** This *plan* does not cover the following:

  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

  - Enhancements to standard equipment and devices that is not *medically necessary*.

  - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.

This exclusion does not apply to *medically necessary* treatment as specifically stated in "Medical Equipment" under the section What We Cover.

- **Educational or Academic Services.** This plan does not cover:

  - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.

  - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.

  - Academic or educational testing.

  - Teaching skills for employment or vocational purposes.

  - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.

  - Teaching manners and etiquette or any other social skills.

  - Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Non-Prescription Drugs.** Non-prescription, over-the-counter drugs or medicines, except as specifically stated in this booklet.

- **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

- **Personal Care and Supplies.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

- **Private Contracts.** Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

- **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice*, *skilled nursing facility* or *residential treatment center*. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child, as required by state or federal law.

- **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care Services" under the section What We Cover. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.

- **Sexual Problems.** Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

- **Sterilization Reversal.** Surgery done to reverse an elective sterilization.

- **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

- **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom claim is made is not an Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans;

4. Medicare, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that provides benefits subject to this provision.

Effect on Benefits
This provision will apply in determining a person's benefits under This Plan for any *calendar year* if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that *calendar year*.

1. If This Plan is the primary plan, then we will figure out its benefits first without taking into account any other plan.

2. If This Plan isn't the primary plan, then we may reduce its benefits so that the benefits of all the plans aren't more than the allowed expense.

3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan*.

If This Plan isn't the primary plan, you may be billed by a health care provider. If you receive a bill, you should submit it to this *medical plan*.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.

2. A plan which covers you through your employer pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your employer's plan, then the plan that covers you as a dependent pays before a plan which covers you through your employer. This might happen if you are covered under This Plan as a retiree.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the year. But if one plan doesn't have a birthday rule provision, that plan's provisions will determine the order of benefits.

   Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

   a. The plan of the parent who has custody, will pay first, unless he or she has remarried.

   b. If the parent with custody has remarried, then the order is as follows:

      i. The plan which covers that child as a dependent of the parent with custody.

      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that child as a dependent of the parent without custody.

iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.

4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan doesn't have a rule about laid-off or retired employees, rule 6 applies.

5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan doesn't have this rule, this rule won't apply.

6. When the rules above don't apply, the plan that has covered you longer pays first unless two of the plans have the same effective date. In this case, allowed expense is split evenly between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this *plan*, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, we may make appropriate adjustment to claims or recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service plans; or
- Other organizations.

In most instances such recovery or adjustment activity shall be limited to the *calendar year* in which the error is discovered.

Prescription Drug Benefit

The prescription drug benefits described in this section are available to active Plan participants and their dependents who are enrolled in a Self-Pay Medical Plan. In addition, retired employees and their dependents who are enrolled in the Self-Pay Medical Plan but are not yet eligible for Medicare are also covered under this benefit.

Note: Your prescription drug benefits are determined by your collective bargaining agreement.

Prescription drug coverage is available in two convenient ways; either through the Retail Pharmacy Card Program or the Mail Order Program. Both programs are administered by OptumRx. You can contact OptumRx directly for information about participating pharmacies, mail-order prescriptions and to order refills:

- The toll free Customer Service number is (800) 797-9791. You can call Customer Service 24 hours a day, 7 days a week.

- The Optum Rx website is ***www.optumrx.com***.

Retail Pharmacy Card Program

The Retail Pharmacy Card Program provides a 100-day supply of medication per prescription or refill at a pharmacy.

This program offers you the convenience of local participating pharmacies for your short-term and immediate prescription drug needs. You can use a participating pharmacy in the OptumRx network or you may purchase your drugs at any pharmacy, the choice is yours each time you need a prescription filled.

Under this program, the following copays apply to most employees:

Type of Prescription Drug	Copay
Generic	$10
Brand-name	$20

Note: You may have a benefit with a $0 copay per prescription or refill, as determined by your collective bargaining agreement.

This is a **mandatory generic** program. Therefore, if you or your doctor requests a brand name drug instead of the generic equivalent, you will be charged the difference in cost between the brand name drug and the generic, in addition to the brand-name drug copay.

When you use an OptumRx network participating pharmacy, you have the advantage of receiving discounted prices and there are no claim forms to file. At participating pharmacies, the pharmacist will use a computerized system to confirm your eligibility for benefits and determine the discounted cost of your prescription. Simply present your prescription card and make your appropriate copay. Your copay depends on whether the prescription is for a generic or brand-name drug.

If you use a non-participating pharmacy, you will have to pay the full cost of the prescription and file a claim with OptumRx to be reimbursed for the cost minus the applicable copay. Claim forms may be obtained from OptumRx or the Fund Office. A claim form must be submitted with copies of the prescription receipt (not cash register receipts) and sent to the address on the form.

Mail Order Program

The Mail Order Program offers you the convenience of receiving at your home up to a 90-day supply of medication per prescription or refill.

The Mail Order Program is designed for maintenance medications for ongoing or chronic conditions. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay amounts are shown in the following table.

Type of Prescription Drug	Copay
Generic	$10
Brand-name	$20

Note: If you are covered by a Maintenance of Benefits (MOB) contract, you may have a benefit with a $0 copay per prescription or refill.

However, if you or your doctor request a brand name drug instead of a generic equivalent, you will be charged the difference in cost between the brand name drug and the generic, in addition to your copay.

How to Use the Mail Order Program

To use the mail order program for the first time, complete a patient profile questionnaire. The questionnaire asks for information about your medical history, blood type, allergies and any other drugs you are taking (prescription and over-the-counter). OptumRx keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription. Follow these steps:

- Obtain an envelope (from OptumRx, the Fund Office or your Local Union). Complete the information requested on the envelope, including your physician's name. OptumRx automatically fills your prescriptions with a generic alternative whenever possible.

- If you are getting a new prescription filled, have your physician prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills. If your physician specifies a brand-name drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your physician to request approval of filling your prescription with a generic drug.

- If you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, OptumRx sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your physician when you request your last refill from OptumRx.

- Send your prescription (and questionnaire if it's your first order) or request for a refill and the appropriate copayment in the postage-paid envelope to OptumRx. You can pay by check, money order, MasterCard or Visa. If use a credit card, include the card number and expiration date. DO NOT SEND CASH.

Within three weeks after ordering a new prescription or two weeks on a refill, your prescription will arrive, at the address you indicated on the envelope, by United Parcel Service (UPS) or U.S. Mail.

If you have any questions or need assistance with the mail order program, contact OptumRx at (888) 290-9990.

Preventive Care Prescription Drugs

In accordance with Federal law, the Plan covers preventive care drugs at 100% with no copay when purchased at an OptumRx network participating pharmacy. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender, age and/or other limits apply. Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

A complete and up-to-date list of preventive care drugs can be found at ***www.hhs.gov/healthcare***. This list may be subject to change.

Briova Rx Speciality Pharmacy

Some specialty oral and injectable medications, such as those used to treat Hepatitis C, Multiple Sclerosis, and Cancer, can be filled by BriovaRx Specialty Pharmacy. This program not only supplies the prescribed medication and related supplies, such as needles and syringes, but also provides clinical support to you to help improve compliance as well as provide convenient delivery. If you are currently being prescribed a medication that can be filled as part of this program, you will receive more information under separate cover.

To begin using BriovaRx Pharmacy, you or your physician can call (877) 342-4596.

Prior Authorization

Under Prior Authorization, prescriptions for certain medications require coverage review before the Plan will cover the medication. If your doctor prescribes one of these medications, your pharmacist or your doctor must call the OptumRx prior authorization department at (800) 711-4555 Option #1. OptumRx will work with your doctor(s) office to get the information for the coverage review. If your doctor does not return the information we ask for, the Prior Authorization request will be denied. OptumRx will notify you and your doctor if the request is denied.

The benefits of Prior Authorization include:

- Promoting safe us of medications
- Helps manage expensive and/or highly used drug categories.

Here are some examples of drug classes that require a prior authorization. This is not a complete list; Blood Formation Agents, Growth Hormone, Hepatitis C, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, Testosterone Replacement, Sleep Disorder, Weight Loss and select pain medications. Some medications may require prior authorization based on age, gender or quantity limits.

Covered Drugs

The prescription Drug Program covers prescription drugs and medicines when prescribed by a physician or other lawful prescriber. This includes:

- All drugs which must be dispensed under federal or state law upon the written prescription.

- Diabetic supplies (if prescribed). Covered diabetic items include:

    - Insulin vials
    - Insulin syringes and needles
    - Insulin pre-filled pen with insulin and needle (disposable)
    - Insulin cartridges
    - Penneedles
    - Blood glucose test strips
    - Urine glucose test strips
    - Lancets

The following diabetic supplies are excluded:

- Insulin pen device
- Lancet devices
- Blood glucose monitors
- Blood glucose monitor supplies

Prescription Drug Program Exclusions

1. Drugs or medication procured or procurable, except as noted above, without a Doctor's written prescription.

2. Immunization agents.

3. Drugs necessary for illness or injury covered by any workers' compensation or occupational disease law, or any state or government agency.

4. Drugs to be taken or administered to the eligible member while he/she is a patient in a hospital, nursing home, rest home, sanitarium etc.

5. Drugs that are experimental, or investigational.

6. Drugs that do not have the full approval of the U.S. Food and Drug Administration (FDA) or the manufacturer for the condition for which they have been prescribed.

7. Appetite suppressants or weight loss agents.

8. Drugs for which no charge is made.

9. Drugs that are lost or stolen.

10. Cosmetic, health or beauty aids.

11. Fertility drugs.

12. Drugs furnished by any other drug or medical service for which no charge is made to the patient.

Important Words to Know

The meanings of key terms used in this booklet are shown below.

Advanced imaging procedures are imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In binding arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

COBRA is a special law that gives you a chance to keep your health plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the *plan* under COBRA.

Copay is the amount you pay to get a *medically necessary* service with an *Anthem Blue Cross HMO provider*. Anthem pays the provider the rest. It is also the amount you pay when you buy *drugs* or medicines from a *drugstore* or through the home delivery program.

Copay Limit is the most you will have to pay in one calendar year in *copays*.

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning; and giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Doctor means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Drug means a prescribed drug approved by the State of California or the federal government for use by the public. Under this *plan*, insulin is thought of as a *prescription drug*.

Drugstore means a store where you get medicine from a licensed pharmacist.

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or unborn child.

An *emergency medical condition* includes a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Out-of-network emergency services shall be paid at the higher of:

(1) The average amount that would be paid to an in-network provider for the same service;
(2) The amount which would be paid under the Usual, Customary and Reasonable (UCR) formula of the Direct Pay PPO Plan without reduction for out-of-network cost sharing generally applicable that Plan;
(3) The amount which Medicare would pay for the service excluding any in-network co-payment or co-insurance imposed with respect to the Participant or Beneficiary.

It is the intent of the Trustees that our-of-network emergency services shall at all times be paid consistent with the requirements of the applicable regulations including but not limited to 29 S.F.R. 2590.715-2719A(b).

Emergency services are services given because of a medical or psychiatric *emergency*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Facility-based care is inpatient or outpatient care provided in a *hospital*, *psychiatric health facility*, or *residential treatment center* for the treatment of *mental health conditions* or substance abuse.

Formulary drug is a *drug* listed on the *Prescription Drug Formulary*.

Generic drugs are *prescription drugs* that we classify as *generic drugs* or that our PBM has classified as *generic drugs* through use of an independent proprietary industry database. *Generic drugs* have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the *brand name drug*.

Health care provider means the kinds of providers, other than M.D.s or D.O.s, that take care of your health and are covered under this *plan*. The provider must:

- Have a license to practice where the care is given and provide a service covered by that license; or
- Be permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only; or
- Give you a service that is paid for under this *plan*.

For nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, "health care provider" includes registered dietitians or another nutritional professional with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O.

Home health agencies are licensed providers who give you skilled nursing and other services in your home. Medicare must approve them as home health providers and/or be recognized by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of *hospices*.

Hospital is a place which provides diagnosis, treatment and care supervised by *doctors*. It must be licensed as a general acute care hospital.

The term hospital will also include *psychiatric health facilities* (only for acute care of a *mental health condition* or substance abuse) and *residential treatment centers*.

Independent practice association (IPA) is a *medical group* made up of a group of *doctors* who practice in private offices. The IPA has an agreement with Anthem to provide health care.

Infertility means: (1) you have a health problem your *doctor* sees as the reason you are unable to have a baby; or (2) you are unable to get pregnant or to carry a pregnancy to a live birth after a year or more of having sex without birth control or after 3 cycles of artificial insemination.

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health condition* or substance abuse disorder, put a *member* and others at risk of harm.

Intensive Outpatient Program is a short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community.

Medical group is a group of *doctors* with an agreement with Anthem to provide health care.

Medically necessary procedures, services, supplies or equipment are those that your Group or Anthem decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized medical community.
- Not primarily for your convenience, or for the convenience of your *doctor* or another provider.

- Not more costly than an alternative service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition.

- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

- There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

- Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Member is the person who gets the health plan from his or her employer or an enrolled family member. An employee may enroll in only one health plan which is sponsored by the *group*.

Mental health conditions include conditions that constitute *severe mental disorders* and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependency.

Partial Hospitalization Program is a structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Plan is the set of benefits talked about in this booklet. From time to time, there may be some changes in what is covered depending on the *agreement* we have with your employer. If changes are made to the plan, you will get a new booklet or a copy of an amendment showing the changes that were made.

Prescription means a written order or refill notice issued by a licensed prescriber for medication.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the Member Services number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

- https://www.healthcare.gov/what-are-my-preventive-care- benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Primary care doctor is a *doctor* who is a member of the *medical group* you have chosen to give you health care. *Primary care doctor*s include general and family practitioners, internists and pediatricians. Certain *specialists* as we may approve may also be designated *primary care doctor*s.

Prior plan is a plan sponsored by your employer which was replaced by this *plan* within 60 days of when it ended. You are considered covered under the prior plan if you:

- Were covered under the prior plan on the date that plan ended;
- Properly enrolled for coverage within 31 days of this *plan's* effective date; and
- Had coverage terminate solely due to the prior plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi- supportive devices which may support the motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Psychiatric health facility is a 24-hour facility, that is:

- Licensed by the California Department of Health Services.
- Qualified to provide short-term inpatient treatment.
- Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Staffed by a professional staff which includes a *doctor* as medical director.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

Reproductive or Sexual Health Care Services as described in California state law which are the following:

- Medical care related to the prevention or treatment of pregnancy.
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease.
- Medical care related to the prevention of a sexually-transmitted disease.
- For alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault.
- HIV testing.

Residential treatment center is an inpatient treatment facility where the *member* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation of *mental health conditions* and substance abuse. The facility must be licensed to provide psychiatric treatment of *mental health conditions* and substance abuse according to state and local laws and requires a minimum of one *doctor* visit per week in the facility. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Severe mental disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Education Code Section 56320).

Skilled nursing facility is a place that gives 24-hour skilled nursing services. It must be licensed and be seen as a skilled nursing facility under Medicare.

Stay is when you are admitted as an inpatient to a *hospital* or nursing facility. It starts when you are admitted to a facility and ends when you are discharged from that facility.

Specialist is a *doctor* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has added training in a specific area of health care.

Specialty care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing referral means a referral by a *primary care doctor* to a *specialist* for more than one visit to the *specialist*, as indicated in the treatment plan, if any, without the *primary care doctor* having to provide a specific referral for each visit.

Surgery center is a facility (not a *hospital* or *doctor's* office) that does surgery when you do not have to stay overnight. The center must be licensed and meet the standards of JCAHCO.

Urgent care means the services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an *emergency*. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem

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, contact the Teamsters Local #856 Plan office at (800) 297-4595. 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 (800) 297-4595 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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	**$2,000**/single or **$3,000**/family for In-Network Providers.	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?	Prescription Drugs, Infertility services, Premiums, balance-billing charges, 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, EPO. See www.anthem.com/ca 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.	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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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	$15/visit	Not covered	--------none--------
	Specialist visit	$15/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, MRIs)	No charge	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/ National	Generic Drugs	$10/prescription (retail) and $10/prescription (home delivery)	In-network Co-Pay plus non-network cost difference	Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Preferred / Brand Name Drugs	$20/prescription (retail) and $20/prescription (home delivery)	In-network Co-Pay plus non-network cost difference	
	Specialty Drugs	30 Day supply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	$50/visit	Covered as In-Network	If directly admitted to a hospital, ER copay is waived. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$15/visit	$50/visit	Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	No charge	Not covered	No charge for Inpatient Physician Fee In-Network Providers. No coverage for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits/benefit period for In- Network Providers.
	Rehabilitation services	$15/visit	Not covered	*See Therapy Services section
	Habilitation services	$10/visit	Not covered	
	Skilled nursing care	No charge	Not covered	100 days limit/benefit period for In- Network Providers.
	Durable medical equipment	No charge	Not covered	--------none--------
	Hospice services	No charge	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Dental Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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.)

- Dental Check-up
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Eye exams for a child
- Long- term care
- Routine eye care (adult)
- Dental care (adult)
- Glasses for a child
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless you have been
- diagnosed with diabetes.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Hearing aids	• Bariatric surgery • Acupuncture	• Chiropractic 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: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219.
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219
California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, www.healthhelp.ca.gov, helpline@dmhc.ca.gov

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

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.

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	$15
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

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	$15
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,455**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$255
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$255**

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

Language Access Services:

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 227-3670

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 227-3670 ይደውሉ።.

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 227-3670

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 227-3670:

Bassa (Bǎsɔ́ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (800) 227-3670.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 227-3670 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 227-3670 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 227-3670。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 227-3670.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 227-3670.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 227-3670 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 227-3670.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 227-3670.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 227-3670.

Gujarati ( ): આ ત આપન ન , ખ વગર મદદ અન મ અહ છ . , (800) 227-3670.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 227-3670.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 227-3670 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 227-3670.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 227-3670.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 227-3670.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 227-3670.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 227-3670

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 227-3670 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 227-3670 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 227-3670.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 227-3670 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (800) 227-3670.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼidiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojíʼ hodíilnih (800) 227-3670.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 227-3670

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 227-3670 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (800) 227-3670 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (800) 227-3670.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (800) 227-3670.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 227-3670 ਤੇ ਕਾਲ ਕਰੋ।

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (800) 227-3670.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 227-3670.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia

talanoa i se tagata faaliliu, vili (800) 227-3670.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (800) 227-3670.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 227-3670.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 227-3670.

Thai ไทยหากคุณมีคำถามใดๆเกี่ยวกับเอกสารนี้คุณมีสิทธิที่จะใช้บริการภาษาฟรีของคุณเพื่อรับความช่วยเหลือและข้อมูล หากคุณต้องการที่จะพูดคุยกับนักแปลโปรดโทร (๘๐๐) 227-3070

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (800) 227-3670.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (800) 227-3670 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (800) 227-3670.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (800) 227-3670.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (800) 227-3670.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368- 1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

PLAN AMENDMENT NO. __

TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND

Pursuant to the authority of Article VII, Section 1, the Trustees hereby make the following change to the Plan:

Beginning with coverage effective July 1, 2019, the Welfare Fund will offer a Direct Pay Exclusive Provider Option (EPO) as a medical plan option. This Exclusive Provider Option (EPO) Medical Plan is only available to employees and retirees who were enrolled in the Anthem Blue Cross HMO Program as of June 30, 2019. The Anthem Blue Cross HMO will be terminated on July 1, 2019.

Effective with claims incurred July 1, 2019 and after the Rules and Regulations of the Teamsters Local Union No. 856 Health & Welfare Fund MEDICAL BENEFIT PROGRAM shall be amended by **adding** the following appendix to the Summary Plan Description titled, **DIRECT PAY MEDICAL PLAN BENEFITS - Exclusive Provider Option (EPO) Plan (For Active Employees and Non-Medicare Retiree/Dependents of Retirees).**

Dated: April _____, 2019

_____ _____

Chairman Secretary

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, Teamsters Local #856 Plan Administrative Office at (800) 297-4595. 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 the Teamsters Local #856 Plan Administrative Office at (800) 297-4595 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/Individual or $500/family	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. Preventive care is 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. 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?	There are no additional out-of-pocket expenses after your family has incurred $2,000 in covered expenses in a calendar year at network providers.	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. Total out-of-pocket expense will never exceed the amount mandated by applicable regulations. For 2019, that amount is **$7,900** for an individual, and **$15,800** for a family.
What is not included in the out-of-pocket limit?	Copayments, deductible, premiums, balance-billing charges, 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/ca or call 1-888-887-3725 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?	No.	You may see a specialist 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
		Network Provider (You will pay the least)	Out-of-Network 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 copayment (Deductible Waived)	40% coinsurance	
	Specialist visit	$20 copayment (Deductible Waived)	40% coinsurance	
	Preventive care/screening/ Immunization	No charge	40% coinsurance	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)	20% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$10 copay/prescription	In-network copay plus non-network cost difference.	Covers up to a 100-day supply (retail and mail order) for Medically Necessary, FDA-approved drugs. If brand is ordered when generic available, you pay cost difference plus copay per prescription. Your Collective Bargaining Agreement may provide for a lower or no copay. You must use the mail order Specialty Pharmacy for Specialty drugs.
	Preferred brand drugs	$20 copay/prescription	In-network copay plus non-network cost difference.	
	Specialty drugs	30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Preauthorization is required.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$20 copayment (Deductible Waived)	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of 100 visits/year
	Rehabilitation services	20% coinsurance	40% coinsurance	Must be pre-certified by Plan's Medical Review Organization. Limit of 24 visits annually for physical, speech and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	For rental or pre-approved purchase. Hearing Aids are covered with a 20% coinsurance, up to $1,000 in any 3 year period, if Collective Bargaining Agreement provides for benefit.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	$15 copay/visit	Your Collective Bargaining Agreement may provide for no copayment. Contact VSP at 800-877-7195 or VSP.com.
	Children's glasses	$15 copay/visit	$15 copay/visit	
	Children's dental check-up	No coinsurance	No coinsurance	Dental Plans I and C have a benefit maximum allowance of $30.40 for a periodic oral evaluation.

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 (covered under a separate dental plan)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Covered under separate vision plan)
- 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	• Chiropractic Care
• Bariatric Surgery (preauthorization required)	• Hearing Aids

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 U.S. Department of Labor, 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: Teamsters Local #856 Plan Administrative Office at (800) 297-4595.

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 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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$250
Copayments	$53
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,363**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$250
Copayments	$20
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$630**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$250
Copayments	$20
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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

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.
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	$15 / visit	Not Covered	None
	Specialist visit	$15 / 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, deductible does not apply.
	Preferred brand drugs	$20 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$20 / 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)	$15 / procedure	Not Covered	None
	Physician/surgeon fees	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 immediate medical attention	Emergency room care	$35 / visit	$35 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$15 / visit	$15 / visit	Non-Plan providers 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: $15 / individual visit. No Charge for other outpatient services; Substance Abuse: $15 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: $7 / 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	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: $15 / visit	Not Covered	None
	Habilitation services	$15 / 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	Not Covered	Not Covered	None
	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.)		
• Children's glasses • Cosmetic surgery • Dental Care (Adult & Child)	• Hearing aids • 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 (20 visit limit / year combined with chiropractic) • Bariatric surgery	• Chiropractic care (20 visit limit / year combined with acupuncture) • 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 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.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	$15
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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	$15
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$850**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

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Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/office/file/index.html*.

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civil es (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jfs (en inglés)* o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html (en inglés)*.

無歧視公告

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性 別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天 24 小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。此外，您還可索取翻譯成您的語言的健康保險計劃資料，以及採用大號字體或其他格式的版本來滿足您的需求。若需更多資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

投訴指任何您或您的授權代表透過流程來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出投訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或咨詢會員服務代表。如果您是 Medicare、MediCal、MRMIP（Major Risk Medical Insurance Program,高風險醫療保險計劃）、MediCal Access、FEHBP （Federal Employees Health Benefits Program, 聯邦僱員健康保險計劃）或 CalPERS 會員，向會員服務代表咨詢尤其重要，因為您可能會有不同的爭議解決方式選擇。

您可透過以下途徑投訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》，地址見《健康服務指南》(Your Guidebook)。
- 將書面投訴信郵寄到健康保險計劃計劃服務設施的會員服務處（地址見《健康服務指南》(Your Guidebook)。
- 給我們的會員服務聯絡中心打免費電話，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。
- 在我們的網站上填寫投訴表，網址是 **kp.org**

如果您在投訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente 的 民權事務協調員（Civil Rights Coordinator）。您也可與 Kaiser Permanente 的民權事務協調員 直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線）。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、 **1-800-464-4000** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

Khmer:នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຣຸນາໂທຣ **1-800-464-4000** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitɬįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000** áko saad bee áká i’iilyeed yídííkił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindzį́’ ahéé’ílkidgóó dóó tsosts’id jį́ ąą’át’é. Dahodílzingóne’ éí dá’deelkaal.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรไปยังหมายเลข **1-800-464-4000** เพื่อขอความช่วยเหลือด้านภาษา สามารถโทรติดต่อได้ตลอด 24 ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ.

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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.
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	$15 / visit	Not Covered	None
	Specialist visit	$15 / 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, deductible does not apply.
	Preferred brand drugs	$20 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$20 / 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)	$15 / procedure	Not Covered	None
	Physician/surgeon fees	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 immediate medical attention	Emergency room care	$35 / visit	$35 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$15 / visit	$15 / visit	Non-Plan providers 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: $15 / individual visit. No Charge for other outpatient services; Substance Abuse: $15 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: $7 / 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	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: $15 / visit	Not Covered	None
	Habilitation services	$15 / 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	Not Covered	Not Covered	None
	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.)		
• Children's glasses • Cosmetic surgery • Dental Care (Adult & Child)	• Hearing aids • 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 (20 visit limit / year combined with chiropractic) • Bariatric surgery	• Chiropractic care (20 visit limit / year combined with acupuncture) • 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 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.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	$15
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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	$15
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$850**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

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Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/office/file/index.html*.

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civil es (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jfs (en inglés)* o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html (en inglés)*.

無歧視公告

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性 別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天 24 小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。此外，您還可索取翻譯成您的語言的健康保險計劃資料，以及採用大號字體或其他格式的版本來滿足您的需求。若需更多資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

投訴指任何您或您的授權代表透過流程來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出投訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或咨詢會員服務代表。如果您是 Medicare、MediCal、MRMIP（Major Risk Medical Insurance Program,高風險醫療保險計劃）、MediCal Access、FEHBP （Federal Employees Health Benefits Program, 聯邦僱員健康保險計劃）或 CalPERS 會員，向會員服務代表咨詢尤其重要，因為您可能會有不同的爭議解決方式選擇。

您可透過以下途徑投訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》，地址見《健康服務指南》(Your Guidebook)。
- 將書面投訴信郵寄到健康保險計劃計劃服務設施的會員服務處（地址見《健康服務指南》(Your Guidebook)。
- 給我們的會員服務聯絡中心打免費電話，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。
- 在我們的網站上填寫投訴表，網址是 **kp.org**

如果您在投訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente 的 民權事務協調員（Civil Rights Coordinator）。您也可與 Kaiser Permanente 的民權事務協調員 直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線）。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、 **1-800-464-4000** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

Khmer:នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຣຸນາໂທຣ **1-800-464-4000** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitɬįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000** áko saad bee áká i’iilyeed yídííkił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindzį́’ ahéé’ílkidgóó dóó tsosts’id jį́ ąą’át’é. Dahodílzingóne’ éí dá’deelkaal.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรไปยังหมายเลข **1-800-464-4000** เพื่อขอความช่วยเหลือด้านภาษา สามารถโทรติดต่อได้ตลอด 24 ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ.

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TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND

JULY 1, 2019 MEDICAL PLAN SELECTION CHANGE FOR ALL ANTHEM HMO PARTICIPANTS - ACTIVE & PRE-MEDICARE RETIREES

MEDICAL PLAN SELECTION FORM

Please check the plan selection box below for your Medical plan selection and return to the Fund office at the below noted address by May 14, 2019. An early response will allow our office to send additional Kaiser Information and the required enrollment form in the event that you select Kaiser. If this form is not received you will be automatically transitioned to the Direct Pay EPO Plan (Anthem Blue Cross) which provides similar coverage to what you currently have under the Anthem HMO Plan.
(Please reference the enclosed materials for detailed plan benefit information)

Please complete the following information:

NAME

SOC. SEC. NO. TEL. NO.

ADDRESS

I WISH TO CHANGE MY CURRENT HOSPITAL-MEDICAL COVERAGE TO:

❑ Direct Pay EPO (Anthem Blue Cross)

❑ Kaiser Plan

❑ Direct Pay PPO (Anthem Blue Cross)

I UNDERSTAND THAT THE ABOVE CHANGES WILL BECOME EFFECTIVE JULY 1, 2019 AND THAT NO FURTHER CHANGES IN HOSPITAL-MEDICAL PLANS MAY BE MADE UNTIL JULY 2020.

SIGNATURE DATE

If you select the Kaiser option on this form, an HMO Enrollment Kit associated with Kaiser will be forwarded directly to your attention.

Note: Based upon a Kaiser selection you must complete the Enrollment Form included within the Kaiser Enrollment Kit and return to the Administrative Office, prior to May 30, 2019, for the change to take place.

Teamsters Local Union No. 856 Health & Welfare Fund
Attn: Accounting & Eligibility
2323 Eastlake Ave E
Seattle, WA 98102-3393

FAX: (206) 926-2699
EMAIL: ~SEAT856Acctclerks@nwadmin.com