



Los Angeles Machinist Benefit Trust

3313 Vincent Rd., Suite 216 • Pleasant Hill, CA 94523 • Phone (800) 499-8121 • Fax (925) 405-0659

October 29, 2021

**TO: ALL ACTIVE CALIFORNIA EMPLOYEES COVERED
UNDER THE LOS ANGELES MACHINIST BENEFIT TRUST**

**RE: OPEN ENROLLMENT PERIOD
Effective January 1, 2022**

During Open Enrollment, you have the opportunity to change your medical and/or dental benefits options. **Please read the comparisons and choices carefully!**

**IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR CHOICE OF
MEDICAL OR DENTAL PLANS, NO ACTION IS REQUIRED**

WHAT ARE MY BENEFITS?

In this packet, you will find:

- A Schedule of Benefits which describes the benefits you are entitled to in accordance with your collective bargaining agreement.
- A "Glossary of Health Coverage" and a "Summary of Benefits and Coverage" for each medical plan choice available to you.
- A Comparison of Benefits showing the medical choices you have for receiving care. If you also have dental benefits, there will be another comparison of your choices under those plans.

WHAT DO I DO IF I HAVE QUESTIONS ON THE PLANS OR MY CHOICES?

Many of your questions may be answered by visiting the Los Angeles Machinist Benefit Trust website at www.lambt.org. Here you can download enrollment forms and obtain important information about your benefit plans.

If you have additional questions about your coverage, contact the Trust Fund Administrative Office. At the top of your Schedule of Benefits Sheet is a plan number. Tell the Administrative Office what that number is. Remember, all employees of the same employer who are covered under this Trust will have the same benefits, but the benefits of another employer may be different. The Plan Number tells the Administrative Office what your benefits are.

WHAT ARE THE DIFFERENCES BETWEEN THE FEE-FOR-SERVICE AND PREPAID (HMO) PLANS?

If you enroll in a Fee-For-Service (or Indemnity) plan, you may use the doctors or dentists of your choice. Both the Fee-For-Service medical and dental plan contains a special Preferred Provider

Option (PPO) that reduces your out-of-pocket expenses if you use those providers. You decide when to use a PPO provider.

If you enroll in a prepaid (HMO) hospital/medical, or dental plan, you will be required to use the doctors, hospitals, or dentists under contract with those prepaid plans. If you obtain services outside of the network, you will be responsible for the charges incurred except in emergency situations which are approved by the prepaid plan. Use of a prepaid plan eliminates the need to file claims and, in most cases, your co-payments are limited. You must also reside within the service area of the prepaid plan to enroll in this option.

WHAT DO I DO NOW?

Carefully review the Benefits Comparison Sheets. Discuss the coverages with your family and decide which plans best suit your needs.

**IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR CHOICE OF
MEDICAL OR DENTAL PLANS, NO ACTION IS REQUIRED**

If you'd like to make changes to your medical or dental plan coverage, please indicate your preference on the attached enrollment form and return it in the enclosed return envelope. If you wish to enroll in any of the prepaid (HMO) plans, please contact the administrative office immediately and request an enrollment packet.

ALL PLAN CHANGES MUST BE RECEIVED BY DECEMBER 16, 2021.

Please contact the Administrative Office at (800) 499-8121 if you have questions about your choices or the enrollment procedures.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT NOTICES

Annual Reminder Required by Federal Law – Regarding Mastectomies and Breast Reconstruction

A federal law called the Women's Health and Cancer Rights Act of 1998 became effective for this Plan on September 1, 1999. Under this law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or Beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the Patient, for;

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please contact the Plan Administrative Office. If you are enrolled in the HMO option plan, please contact the HMO.

Newborns' and Mothers' Health Protection Act of 1996 Notice

We remind you that under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).



Rael & Letson

LOS ANGELES MACHINIST BENEFIT TRUST
Low Option Benefits Comparison 2022

| Benefits | Kaiser Low HMO | UHC Low Option |
|---|--|--|
| Overall Deductible | \$0 | \$0 |
| Are there services covered before you meet your deductible? | Not Applicable. | Yes preventive and primary care. |
| Are there other deductibles for specific services? | No. | No |
| Out-of-pocket limit for this plan | \$1,500 Individual / \$3,000 Family | \$1,000 individual/ \$3,000 family |
| Not included in the out-of-pocket limit | Premiums, health care this plan doesn't cover, and services indicated in chart | copayments for certain services, premiums, balance billing charges |
| 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. | Yes |
| Do you need a referral to see a specialist? | Yes, but you may self-refer to certain specialists. | Yes - written or oral based upon medical policy |
| | Plan Provider | Plan Provider |
| Health care provider's office or clinic: | | |
| Primary care visit to treat an injury or illness | \$25 copay | \$25 office; \$5 virtual |
| Specialist visit | \$25 copay | \$30 copay |
| Preventive care/screening/immunization | No Charge | No charge |
| Tests: | | |
| Diagnostic test (X-ray, blood work) | No Charge | No charge |
| Imaging (CT/PET scans, MRIs) | No Charge | No charge |
| Prescription Drugs: | | |
| Generic drugs | \$10 copay | Tier 1 - \$10 copay ; Tier 2 and 3 \$30 copay |
| Preferred Brand drugs | \$30 copay | Tier 1 - \$10 copay ; Tier 2 and 3 \$30 copay |
| Non-Preferred Brand drugs | Same as preferred brand drugs | Tier 1 - \$10 copay ; Tier 2 and 3 \$30 copay |
| Specialty drugs | \$30 copay | Not applicable |
| Outpatient Surgery: | | |
| Facility fee (e.g., ambulatory surgery center) | \$25 copay /procedure | \$50 copay/ admit |
| Physician/surgeon fees | No Charge | No charge |
| Immediate Medical Attention: | | |
| Emergency room care | \$100 visit | \$100 copay/ admit |
| Emergency medical transportation | No Charge | No charge |
| Urgent care | \$25 copay | \$25 copay |
| Hospital: | | |
| Facility fee (e.g., hospital room) | \$100/ admission | \$100/ admit |
| Physician/surgeon fees | No Charge | No charge |



Rael &
Letson

LOS ANGELES MACHINIST BENEFIT TRUST
Low Option Benefits Comparison 2022

| Benefits | Kaiser Low HMO | UFC Low Option |
|--|--|--|
| Mental Health, Behavioral Health, or Substance Abuse: | | |
| Outpatient services | \$25 copay; \$5/day for other outpatient | \$25 copay office; all other no charge |
| Inpatient services | \$100/ admission | \$100 / admit |
| Pregnancy: | | |
| Office visits | No Charge | No charge |
| Childbirth/delivery professional services | No Charge | No charge |
| Childbirth/delivery facility services | \$100 admission | \$100/ admit |
| Assistance with Recovery or Other Special Health Needs: | | |
| Home health care | No Charge | No charge |
| Rehabilitation services | \$100/ admit; \$25 visit outpatient | \$25 copay |
| Habilitative services | \$25 visit | \$25 copay |
| Skilled nursing care | No Charge | \$100 / admit |
| Durable medical equipment | No Charge | No charge |
| Hospice services | No Charge | No charge |
| Children's Dental or Eye Care: | | |
| Children's eye exam | No Charge | \$25 copay |
| Children's glasses | Not Covered | Not covered |
| Children's dental check-up | Not Covered | Not covered |



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 <u>copayment</u> or <u>coinsurance</u> may apply. | |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. | |
| What is the out-of-pocket limit for this plan? | \$1,500 Individual / \$3,000 Family | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> . | |
| 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 <u>network providers</u> . | This plan uses a <u>provider network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. | |
| Do you need a referral to see a specialist? | Yes, but you may self-refer to certain <u>specialists</u> . | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . | |

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

| Common Medical Event | Services You May Need | What You Will Pay 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 | \$25 / visit | Not Covered | None |
| | <u>Specialist</u> visit | \$25 / visit | Not Covered | None |
| | <u>Preventive care</u> / <u>screening</u> / immunization | No Charge | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (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 <u>prescription drug coverage</u> 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 <u>formulary</u> guidelines. No Charge for Contraceptives. |
| | Preferred brand drugs | \$30 / prescription | Not Covered | Up to a 100-day supply retail and mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives. |
| | Non-preferred brand drugs | Same as preferred brand drugs | Not Covered | Same as preferred brand drugs when approved through exception process. |
| | <u>Specialty drugs</u> | \$30 / prescription | Not Covered | Up to a 30-day supply retail. Subject to <u>formulary</u> guidelines. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$25 / 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 | <u>Emergency room care</u> | \$100 / visit | \$100 / visit | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | None |
| | <u>Urgent care</u> | \$25 / visit | \$25 / visit | Non-Plan providers covered when temporarily outside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$100 / admission | Not Covered | None |
| | Physician/surgeon fee | No Charge | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Mental / Behavioral Health: \$25 / individual visit. No Charge for other outpatient services; Substance Abuse: \$25 / individual visit. \$5 / day for other outpatient services | Not Covered | Mental / Behavioral Health: \$12 / group visit; Substance Abuse: \$5 / group visit. |
| | Inpatient services | \$100 / admission | Not Covered | None |
| | 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). |
| If you are pregnant | Childbirth/delivery professional services | No Charge | Not Covered | None |
| | Childbirth/delivery facility services | \$100 / admission | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|----------------------------------|---|---|---|
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | Not Covered | Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year. |
| | <u>Rehabilitation services</u> | Inpatient: \$100 / admission; Outpatient: \$25 / visit | Not Covered | None |
| | <u>Habilitation services</u> | \$25 / visit | Not Covered | None |
| | <u>Skilled nursing care</u> | No Charge | Not Covered | Up to 100 days maximum / benefit period. |
| | <u>Durable medical equipment</u> | No Charge | Not Covered | Requires prior authorization. |
| | <u>Hospice service</u> | No Charge | Not Covered | None |
| | <u>Children's eye exam</u> | No Charge | Not Covered | None |
| If your child needs dental or eye care | 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
- Chiropractic care
- 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 (plan provider referred)
- Bariatric surgery
- 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](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), visit www.HealthCare.gov or call 1-800-318-2596.

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

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

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

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

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

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

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$25
- **Hospital (facility) copayment** \$100
- **Other (blood work) copayment** \$0

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

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$100 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$150 |

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** \$25
- **Hospital (facility) copayment** \$100
- **Other (blood work) copayment** \$0

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

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$800 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$25
- **Hospital (facility) copayment** \$100
- **Other (x-ray) copayment** \$0

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

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$200 |

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

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 Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities 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. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call 1-800-464-4000 (TTY 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.

You may submit a grievance in the following ways:

- **By phone:** Call member services at 1-800-464-4000 (TTY 711) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at 1-800-464-4000 (TTY 711) and ask to have a form sent to you.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses).
- **Online:** Use the online 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:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

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 Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at 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 7 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. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al 1-800-788-0616 (TTY 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.

Puede presentar una queja de las siguientes maneras:

- Por teléfono: Llame a servicio a los miembros al 1-800-788-0616 (TTY 711) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- Por correo postal: Llámenos al 1-800-788-0616 (TTY 711) y pida que se le envíe un formulario.
- En persona: Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en kp.org/facilities [haga clic en "Español"]) para obtener las direcciones).
- En línea: Use el formulario en línea en nuestro sitio web en en.kp.org/espanol.

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:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

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 Civiles (Office for Civil Rights Complaint Portal), en ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). 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 7 天每天 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服務，包括手語服務，以及殘障人士輔助器材和服務。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。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電 **1-800-757-7585** (TTY711)。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。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)，或諮詢會員服務代表。

您可透過以下方式提出申訴：

- 透過電話：請致電 **1-800-757-7585** (TTY 711) 與會員服務部聯絡，服務時間為每週 7 天，每天 24 小時（節假日除外）。
- 透過郵件：請致電 **1-800-757-7585** (TTY 711) 與我們聯絡並請我們將表格寄給您。
- 親自遞交：在計劃設施的會員服務辦事處填寫投訴或福利索賠／申請表（請參閱 kp.org/facilities 上的保健業者名錄以查看地址）
- 線上：使用我們網站上的線上表格，網址為 kp.org

如果您在提交申訴時需要協助，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：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站(Office for Civil Rights Complaint Portal)向美國衛生與民眾服務部(U.S. Department of Health and Human Services)民權辦公室(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 Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。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: Մա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրով ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանկանություն ստանալ լեզվի օգնություն: Զանգահարելք օրը 24 ժամ, շաբաթը 7 օր՝ բացի անոց 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 بگیرید و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانه روز 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 कुछियों 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 ឲ្យបានយល់ដឹងពីព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지를입니다. 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, ກະລຸນາໂທສ **1-800-464-4000** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ.

Navajo: Dii éi hane' b'íhólnihii át'éego Kaiser Permanente yee nihalne'. Dii hane' igíí doo hazhó'ó bik'í diit'ingóó t'áá shqodí koji' hodílnih **1-800-464-4000** áko saad bee áká i'íilyeed yídííkiit. K'we'é áká aná'á'wo' t'áá átahjí' naadindjii' ahée' íl'kidgóó dóó tsoosts'í d jí áá'át'é. Dahodí'zingóne' 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 ਫੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਭੋਲੀਆਂ 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 lingüística. 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, visit www.welcometohc.com/uhcwest or by calling 1-800-624-8822. 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 1-800-624-8822 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? | Yes. <u>Preventive care</u> and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | For <u>participating providers</u> \$1,000 individual / \$3,000 family. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See www.welcometohc.com/uhcwest or call 1-800-624-8822 for a list of <u>participating providers</u> . | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use a <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>participating provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | Yes, written or oral approval is required, based upon medical policies. | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | \$25 copay / office visit and \$5 copay / Virtual visits by a designated virtual participating provider | Not covered | If you receive services in addition to office visit, additional copayments or coinsurance may apply. |
| | Specialist visit | \$30 copay / visit | Not covered | Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments or coinsurance may apply. |
| | 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, MRIs) | No charge | Not covered | |

| Common Medical Event | Services You May Need | Participating Provider (You will pay the least) | What You Will Pay Non-Participating Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest.</p> | Tier 1 – Generic drugs | \$10 <u>copay</u> / prescription retail \$10 <u>copay</u> / prescription mail order | Not covered | <p><u>Participating Provider</u> means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u>, from a pharmacy designated by us. Certain preventive medications (including certain contraceptives) are covered at No charge. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your <u>plan</u>.</p> |
| | Tier 2 – Preferred Brand drugs | \$30 <u>copay</u> / prescription retail \$30 <u>copay</u> / prescription mail order | Not covered | |
| | Tier 3 – Non-Preferred Brand drugs | \$30 <u>copay</u> / prescription retail \$30 <u>copay</u> / prescription mail order | Not covered | |
| | Tier 4 – <u>Specialty drugs</u> | Not applicable | Not covered | |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | \$50 <u>copay</u> / admit | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | |
| | <u>Emergency room care</u> | \$100 <u>copay</u> / visit | \$100 <u>copay</u> / visit | |
| <p>If you need immediate medical attention</p> | <u>Emergency medical transportation</u> | No charge | No charge | None |
| | <u>Urgent care</u> | \$25 <u>copay</u> / visit | \$75 <u>copay</u> / visit | If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> or <u>coinsurance</u> may apply. |
| | Facility fee (e.g., hospital room) | \$100 <u>copay</u> / admit | Not covered | None |
| <p>If you have a hospital stay</p> | Physician/surgeon fees | No charge | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 <u>copay</u> / office visit and No charge for all other outpatient services | Not covered | Substance abuse outpatient and inpatient services are covered at No charge. |
| | Inpatient services | \$100 <u>copay</u> / admit | Not covered | |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional <u>copayments</u> or <u>coinsurance</u> may apply. <u>Maternity care</u> may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to 100 visits per calendar year. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | \$100 <u>copay</u> / admit | Not covered | |
| | <u>Home health care</u> | No charge | Not covered | |
| If you need help recovering or have other special health needs | <u>Rehabilitation services</u> | \$25 <u>copay</u> / visit | Not covered | Coverage is limited to physical, occupational, and speech therapy. No coverage for <u>Habilitative services</u> . Up to 100 days per benefit period. None If inpatient admission, subject to inpatient <u>copayments</u> or <u>coinsurance</u> . 1 exam per year. None No coverage for Dental check-ups. |
| | <u>Habilitative services</u> | Not covered | Not covered | |
| | <u>Skilled nursing care</u> | \$100 <u>copay</u> / admit | Not covered | |
| | <u>Durable medical equipment</u> | No charge | Not covered | |
| | <u>Hospice services</u> | No charge | Not covered | |
| If your child needs dental or eye care | Children's eye exam | \$25 <u>copay</u> / visit | Not covered | |
| | 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitative services
- Infertility treatment
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- 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 are: Department of Managed Health Care California Help Center, 980 9th street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or <http://www.healthhelp.ca.gov>, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov 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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>.

Additionally, a consumer assistance program may help you file your [appeal](#). Contact Department of Managed Health Care California Help Center, 980 9th street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or <http://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 1-800-624-8822.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-8822.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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 participating provider pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- 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 \$12,800

In this example, Peg would pay:

Cost Sharing

| | |
|---------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$100 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |

The total Peg would pay is \$160

Managing Joe's type 2 Diabetes

(a year of routine participating provider care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- 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 \$7,400

In this example, Joe would pay:

Cost Sharing

| | |
|---------------------------|---------|
| Deductibles | \$0 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$30 |

The total Joe would pay is \$1,030

Mia's Simple Fracture

(participating provider emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$30
- Hospital (facility) copayment \$100
- 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 \$1,900

In this example, Mia would pay:

Cost Sharing

| | |
|---------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |

The total Mia would pay is \$300

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822.

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

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

Chinese

重要語言資訊：

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打HMO 協助專線 1-888-466-2219。

Arabic

معلومات مهمة عن اللغة: ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يرجى الاتصال بخطتك الصحية على: الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian

Հարեցողք Լեզվապարտադրությունները: Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք սպասել անվճար թարգմանչի կամ թարգմանության անվճար ծառայությունների: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություններ: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ UnitedHealthcare of California 1-800-624-8822 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

Cambodian

ព័ត៌មានសំខាន់អំពីភាសា: អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវាទៅខាងក្រោម។ អ្នកអាចទទួលបានអ្វីៗ ឬសេវាការបំប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាផ្សេងៗ ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលបានជំនួយជាភាសា របស់អ្នក សូមស្នើសុំទៅជាមួយស្នងការរបស់អ្នក តាមលេខ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ ប្រសិនបើអ្នកត្រូវការជំនួយប្រែសម្រួល HMO តាមលេខ 1-888-466-2219។

Farsi

اطلاعات مهم در مورد زبان:
شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 711 / TTY: 1-800-624-8822 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ्त में उपलब्ध कराई जा सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711 पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

Hmong

COV NTAUB NTAWV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ:

お客様には、以下権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。UnitedHealthcare of California 1-800-624-8822 / TTY: 711. この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean 중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਹਤਵਪੂਰਨ ਤਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਆਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਤਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਅਪਣੀ ਤਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਅਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਚੈਲਮ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalín nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

Thai

ข้อมูลสำคัญเกี่ยวกับภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

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08/18

Nondiscrimination Notice and Access to Communication Services

UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Network Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its Health Plans.

Free services are available to help you communicate with us such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your health plan ID card.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)
Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

2022 DENTAL BENEFIT COMPARISON

HIGH

| Procedure | Indemnity Plan 8 ¹ | CIGNA ² |
|---|-------------------------------|---|
| Annual Maximum | \$ 2,500 | None |
| Dental Preferred Provider | 100% | Not applicable |
| <u>Preventative & Diagnostic -</u> | | |
| X-rays, Complete | \$ 85.00 ³ | No charge |
| X-rays, First Periapical | 25.00 | No charge |
| X-rays, Next Periapical | 12.00 | No charge |
| X-rays, 2 Bitewings | 36.00 ³ | No charge |
| X-rays, 4 Bitewings | 47.00 ³ | No charge |
| Prophylaxis, Adult | 61.00 | No charge |
| Prophylaxis, Child | 60.00 | No charge |
| <u>Restorative -</u> | | |
| Amalgam, 1 Surface | \$ 70.00 | No charge |
| Amalgam, 2 Surfaces | 85.00 | No charge |
| Composite Resin, 1 Surface | 100.00 | No charge |
| Crown, Porcelain with Metal | 650.00 | \$60.00 ⁴ |
| <u>Other -</u> | | |
| Perio Scale | \$ 175.00 | No charge |
| Simple Extraction | 85.00 | No charge |
| Orthodontia for Dependent Children and Adults | See your Schedule of Benefits | \$1,500 ⁵ or \$2,000 ⁶ 2-year maximum length of treatment; additional usual and customary charges thereafter |

¹ The benefits listed are amounts payable by the Plan if a non-contracting provider is used; use of a contracting provider will limit your co-payment.

² Sample co-payments only, refer to CIGNA brochure for other co-payments.

³ Includes exam. The Plan does NOT pay for routine exams when routine x-rays are taken.

⁴ Plus cost of metal.

⁵ Children, plus start up fees.

⁶ Adults and Adult Children, plus start up fees.

Note: This is only a summary of your benefits. You should refer to the Administrative Office or CIGNA's Evidence of Coverage for a binding and detailed description of benefits.

2021 DENTAL BENEFIT COMPARISON

MEDIUM

| Procedure | Indemnity Plan 7 ¹ | CIGNA ² |
|---|-------------------------------|---|
| Annual Maximum | \$ 1,500 | None |
| Dental Preferred Provider | 100% | Not applicable |
| <u>Preventative & Diagnostic -</u> | | |
| X-rays, Complete | \$ 53.90 ³ | No charge |
| X-rays, First Periapical | 11.45 | No charge |
| X-rays, Next Periapical | 7.65 | No charge |
| X-rays, 2 Bitewings | 19.10 ³ | No charge |
| X-rays, 4 Bitewings | 26.75 ³ | No charge |
| Prophylaxis, Adult | 47.75 | No charge |
| Prophylaxis, Child | 38.20 | No charge |
| <u>Restorative -</u> | | |
| Amalgam, 1 Surface | \$ 43.55 | No charge |
| Amalgam, 2 Surfaces | 55.45 | No charge |
| Composite Resin, 1 Surface | 51.50 | No charge |
| Crown, Porcelain with Metal | 412.80 | \$60.00 ⁴ |
| <u>Other -</u> | | |
| Perio Scale | \$ 99.00 | No charge |
| Simple Extraction | 43.55 | No charge |
| Orthodontia for Dependent Children and Adults | See your Schedule of Benefits | \$1,500 ⁵ or \$2,000 ⁶ ; 2-year maximum length of treatment; additional usual and customary charges thereafter |

¹ The benefits listed are amounts payable by the Plan if a non-contracting provider is used; use of a contracting provider will limit your co-payment.

² Sample co-payments only, refer to CIGNA brochure for other co-payments.

³ Includes exam. The Plan does NOT pay for routine exams when routine x-rays are taken.

⁴ Plus cost of metal.

⁵ Children, plus start up fees.

⁶ Adults and adult children, plus start up fees.

Note: This is only a summary of your benefits. You should refer to the Administrative Office or CIGNA's Evidence of Coverage for a binding and detailed description of benefits.

2021 DENTAL BENEFIT COMPARISON

LOW

| Procedure | Indemnity Plan 6¹ | CIGNA² |
|---|-------------------------------------|---|
| Annual Maximum | \$ 1,500 | None |
| Dental Preferred Provider | 80% | Not applicable |
| <u>Preventative & Diagnostic -</u> | | |
| X-rays, Complete | \$ 45.00 ³ | No charge |
| X-rays, First Periapical | 14.00 | No charge |
| X-rays, Next Periapical | 5.00 | No charge |
| X-rays, 2 Bitewings | 15.00 ³ | No charge |
| X-rays, 4 Bitewings | 20.00 ³ | No charge |
| Prophylaxis, Adult | 30.00 | No charge |
| Prophylaxis, Child | 30.00 | No charge |
| <u>Restorative -</u> | | |
| Amalgam, 1 Surface (Permanent) | \$ 30.00 | No charge |
| Amalgam, 2 Surfaces (Permanent) | 40.00 | No charge |
| Composite Resin, 1 Surface | 40.00 | No charge |
| Crown, Porcelain with Metal | 300.00 | \$60.00 ⁴ |
| <u>Other -</u> | | |
| Perio Scale | \$ 40.00 | No charge |
| Simple Extraction | 30.00 | No charge |
| Orthodontia for Dependent Children and Adults | See your Schedule of Benefits | \$1,500 ⁵ or \$2,000 ⁶ ; 2-year maximum length of treatment; additional usual and customary charges thereafter |

¹ The benefits listed are amounts payable by the Plan if a non-contracting provider is used; use of a contracting provider will limit your co-payment.

² Sample co-payments only, refer to CIGNA brochure for other co-payments.

³ Includes exam. The Plan does NOT pay for routine exams when routine x-rays are taken.

⁴ Plus cost of metal.

⁵ Children, plus start up fees.

⁶ Adults adult children, plus start up fees.

Note: This is only a summary of your benefits. You should refer to the Administrative Office or CIGNA's Evidence of Coverage for a binding and detailed description of benefits.



LOS ANGELES MACHINIST BENEFIT TRUST

OBTAINING SERVICES IS EASY

Follow these simple steps:

- Select a provider.** Select a participating vision care provider by visiting www.MESVision.com. Obtaining services from a Participating Provider will maximize your benefits.
- Make an appointment.** Call the Participating Provider of your choice to make an appointment and inform them of your vision coverage.
- You're done! Your doctor will take care of the rest.** The Participating Provider will contact MESVision to verify your eligible benefits and submit a claim for payment for services covered by your plan.
- If covered services are received from a non-participating provider, you are responsible for paying the provider in full. You or the provider must submit the itemized bill and a copy of your prescription with the Claim Form to MESVision. Reimbursement will be made to the insured person up to the schedule of allowances shown for non-participating providers.

LIMITATIONS

Contact Lenses and fitting except as specifically provided; Eyewear when there is no prescription change, except when benefits are otherwise available; Non-standard lenses, including, but not limited to; Progressive, Photochromic, hi-index, Polycarbonate, occupational lenses, beveled, faceted, coated or oversize; Tints other than pink or rose #1 or #2, except as specifically provided; Two pair of glasses in lieu of bifocals, unless prescribed; New-patient intermediate examinations. When an Enrollee selects a different provider to perform the intermediate examination, the Enrollee will be responsible for the difference between the intermediate examination allowance and the comprehensive examination allowance. To maximize benefits, the patient should return to the original provider; Non-prescription (Plano) eyewear, except when specifically covered.

EXCLUSIONS

Any eye examination required by the employer as a condition of employment; Any covered services provided by another vision plan; Conditions covered by Workers' Compensation; Contact lens insurance of care kits; Frame cases; Covered Services which began prior to the Enrollee's effective date or after benefits have been terminated; Charges for which the Enrollee is not legally obligated to pay; Covered Services required by any government agency or program federal, state or subdivision thereof; Covered Services performed by a Close Relative or by an individual who ordinarily resides in the Enrollee's home; Covered Services obtained from a Non-Participating Provider; Medical or Surgical treatment of the eyes; Orthoptics, vision training or Subnormal or Low Vision Aids; Services that are Experimental or Investigational in nature; Services for treatment directly related to any totally disabling condition, illness or injury; Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are otherwise available; In connection with war or any act of war whether declared or undeclared; a condition or accident occurring while on full-time active duty in the armed forces or any country or combination of countries.

This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract.

D \$130 \$105 \$75 \$75 \$105 Co-Pay \$0

SUMMARY OF VISION BENEFITS

Benefits:

| | |
|----------------------------|---------------------------|
| Co-pay: | \$0 |
| Comprehensive Vision Exam: | One every 12 months |
| Lenses* (Standard) | One pair every 12 months |
| Frame:** | One frame every 24 months |
| Contact Lenses:*** | One pair every 12 months |

The Policy provides full coverage for Covered Services when you go to a Participating Provider of the MESVision network. If Covered Services are provided by a Non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances.

**"Standard" lenses (plastic) fit any frame with an eye size less than 61mm.

| | Participating Provider | Non-Participating Provider |
|----------------------------|------------------------|----------------------------|
| Ophthalmologic Examination | Covered | Up to \$ 40.00 |
| Optometric Examination | Covered | Up to \$ 40.00 |
| Single Vision Lenses* | Covered | Up to \$ 30.00 |
| Bifocal Lenses* | Covered | Up to \$ 50.00 |
| Trifocal Lenses* | Covered | Up to \$ 65.00 |
| Progressive Lenses | Up to \$ 89.50 | Up to \$ 65.00 |
| Polycarbonate Lenses**** | Up to \$ 85.00 | Up to \$ 55.00 |
| Aphakic Monofocal | Covered | Up to \$ 125.00 |
| Aphakic Multifocal | Covered | Up to \$ 125.00 |
| Frame** | Up to \$130.00 | Up to \$ 75.00 |
| Contact Lenses *** | | |
| Medically Necessary | Covered | Up to \$ 250.00 |
| Cosmetic or Convenience | Up to \$105.00 | Up to \$ 105.00 |

** Participating Providers allow a selection of frames that retail up to **\$130.00** with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above **\$130.00**. If the lenses received are 61 millimeters or above, the charge for the oversize lenses is your responsibility. "The retail frame allowance will be converted to wholesale or warehouse equivalent prices at category 5 or 6 provider locations (please refer to the Plan's website at www.MESVision.com). The wholesale or warehouse equivalent may be approximately 30% less than the retail frame allowance; please confirm this benefit before ordering your eyewear."

*** This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to **\$105.00** toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are medically necessary, they are a fully covered benefit. Approval from MESVision is required. Please refer to your Policy if you require additional information.

**** For Dependent Children through age 18

Discounts: A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can review their Participating Provider Directory, call MESVision or visit www.MESVision.com. Discounts are available through TLVision for conventional and custom LASIK procedures with the TLVision Advantage Program.

If you have any questions about your vision benefits, please contact Medical Eye Services at:
PO Box 25209; Santa Ana, CA 92799
800/877-6372 or www.MESVision.com



Underwritten By:
Gerber Life Insurance Company
A separate subsidiary of Gerber Products
Home Office: White Plains, NY 10605