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).

LOS ANGELES MACHINIST BENEFIT TRUST

Medium Option Benefits Comparison 2022

Benefits	Anthem Indemnity Medical Plan		Kaiser Medium HMO	UHC Medium Option
Overall Deductible	**$100/Individual; $200 family**		**$0**	**$0**
Are there services covered before you meet your deductible?	**No**		**Not Applicable.**	**Yes preventive and primary care.**
Are there otherdeductibles for specific services?	**No**		**No.**	**No**
Out-of-pocket limit for this plan	**$7,100/person; $13,000 family**	**None**	**$1,500 Individual / $3,000 Family**	**$1,000 individual/ $3,000 family**
Not included in the out-of-pocket limit	**Premiums, and balance billing**		**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**		**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?	**No**		**Yes, but you may self-refer to certain specialists.**	**Yes - written or oral based upon medical policy**
	PPO	**NON PPO**	**Plan Provider**	**Plan Provider**
Health care provider's office or clinic:				
Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	$15 copay	$15 office; $5 virtual
Specialist visit	20% coinsurance	30% coinsurance	$15 copay	$20 copay
Preventive care/screening/ immunization	No Charge	30% coinsurance	No Charge	No charge
Tests:				
Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	No Charge	No charge
Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	No Charge	No charge
Prescription Drugs:				
Generic drugs	$10 copay	$10 copay	$10 copay	Tier 1 - $10 coppay ; Tier 2 and 3 $30 copay
Preferred Brand drugs	$30/$60 copay	$30/$60 copay	$30 copay	Tier 1 - $10 coppay ; Tier 2 and 3 $30 copay
Non-Preferred Brand drugs	$30/$60 copay	$30/$60 copay	Same as preferred brand drugs	Tier 1 - $10 coppay ; Tier 2 and 3 $30 copay
Specialty drugs	$30/$60 copay	$30/$60 copay	$30 copay	Not applicable
Outpatient Surgery:				
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	$15 copay /procedure	$50 copay/ admit
Physician/surgeon fees	20% coinsurance	30% coinsurance	No Charge	No charge
Immediate Medical Attention:				
Emergency room care	20% coinsurance	30% coinsurance	$100 visit	$100 copay/ admit
Emergency medical transportation	20% coinsurance	30% coinsurance	No Charge	No charge
Urgent care	20% coinsurance	30% coinsurance	$15 copay	$15 copay
Hospital:				
Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	$100/ admission	$100/ admit
Physician/surgeon fees	20% coinsurance	30% coinsurance	No Charge	No charge

LOS ANGELES MACHINIST BENEFIT TRUST

Medium Option Benefits Comparison 2022

Benefits	Anthem Indemnity Medical Plan		Kaiser Medium HMO	UHC Medium Option
Mental Health, Behavioral Health, or Substance Abuse:				
Outpatient services	20% coinsurance	30% coinsurance	$15 copay; $5/day for other outpatient	$15 copay office; all other no charge
Inpatient services	20% coinsurance	30% coinsurance	$100/ admission	$100 / admit
Pregnancy:				
Office visits	No Charge	30% coinsurance	No Charge	No charge
Childbirth/delivery professional services	No Charge	30% coinsurance	No Charge	No charge
Childbirth/delivery facility services	No Charge	30% coinsurance	$100 admission	$100/ admit
Assistance with Recovery or Other Special Health Needs:				
Home health care	20% coinsurance	30% coinsurance	No Charge	No charge
Rehabilitation services	20% coinsurance	30% coinsurance	$100/ admit; $15 visit outpatient	$15 coppay
Habilitative services	Not Covered	Not Covered	$15 visit	$15 coppay
Skilled nursing care	20% coinsurance	30% coinsurance	No Charge	$100 / admit
Durable medical equipment	20% coinsurance	30% coinsurance	No Charge	No charge
Hospice services	20% coinsurance	30% coinsurance	No Charge	No charge
Children's Dental or Eye Care:				
Children's eye exam	$5 copay	Up to $50	No Charge	$15 copay
Children's glasses	No Charge	Up to $300	Not Covered	Not covered
Children's dental check-up	No Charge	20% coinsurance	Not Covered	Not covered

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the summary plan description or plan document at www.lambt.org or by calling **1-800-499-8121.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person **/$200** family. Unused amount for deductible in last quarter can be used to satisfy next year's deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services
Is there an out–of–pocket limit on my expenses?	Yes. For PPO providers **$7,100** per person; **$13,700** per family. **No** out-of-pocket limit for non-PPO providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on Page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. see www.Anthem.com/ca or call **1 (323) 278-7030** or **1 (800) 499-8121** for a list of participating providers (PPO).	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred,** or participating **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your summary plan description or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Specialist visit	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Other practitioner office visit	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Preventive care/screening/immunization	No charge	30% coinsurance	Deductible does not apply - PPO
If you have a test	Diagnostic test (x-ray, blood work)	20% after ded – other than preventive	30% coinsurance	No charge or deductible for preventive; (30% based on UCR - OON)
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.procarerx.com.	Generic drugs	$10 co-pay per prescription	$10 co-pay per prescription	Maximum day supply – 30-day retail; 60-day mail; No charge, no deductible for birth control drugs and devices - PPO
	Preferred brand drugs	$30/$60 co-pay per prescription	$30/$60 co-pay per prescription	Preferred and non-preferred brand drugs are only covered when medically necessary or a generic is not available. If brand is chosen instead, copay is difference in cost between generic and brand.
	Non-preferred brand drugs	$30/$60 co-pay per prescription	$30/$60 co-pay per prescription	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	$30/$60 co-pay per prescription	$30/$60 co-pay per prescription	Prior authorization required – 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Physician/surgeon fees	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	After deductible same basis as PPO
	Emergency medical transportation	20% coinsurance	20% coinsurance	After deductible same basis as PPO
	Urgent care	20% coinsurance	20% coinsurance	After deductible same basis as PPO
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance e	30% coinsurance	After deductible (30% based on UCR)
	Physician/surgeon fee	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
If you have mental health, behavioral health, or substance abuse needs. For help, contact www.mhn.com or 1-(800) 327-7701 for	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Substance use disorder outpatient services	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	After deductible (30% based on UCR)
	Delivery and all inpatient services	No charge	30% coinsurance	After deductible (30% based on UCR)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	30 days/calendar year; After deductible
	Rehabilitation services	20% coinsurance	30% coinsurance	After deductible; 23 visits combined – rehab, acupuncture, chiropractic, physical, speech, respiratory and vision therapy
	Habilitation services	Not covered	Not covered	Not considered medically necessary
	Skilled nursing care	20% coinsurance	30% coinsurance	After deductible 30 day limit maximum
	Durable medical equipment	20% coinsurance	30% coinsurance	After deductible (30% based on UCR)
	Hospice service	20% coinsurance	30% coinsurance	After deductible - 30 day maximum
If your child needs dental or eye care	Eye exam	$5 copay	Up to $50	Limited to one exam and lenses per year; out-of-network benefits scheduled

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Glasses	No charge	Up to $300	Limited to 1 frame every 2 years; out of network vision benefits - scheduled
	Dental check-up	No charge	20% coinsurance	Up to $2,500 per year for all dental services to age 19 – indemnity dental plan; scheduled copays in the prepaid dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Treatment that is not medically necessary
- Any type of artificial insemination
- Adult vision and dental services
- Weight control programs
- Cosmetic surgery
- Genetic counseling
- Non-PPO substance abuse and mental health services

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Refer to MHN for Employee Assistance Program details MHN 1-(800) 327-7701
- Refer to Vision Service Plan (VSP) 1- (800) 877-7195; and, Medical Eye Service (MES) 1 (800) 638-3120
- Refer to Dental Plans through United Concordia for prepaid and indemnity dental coverage 1- (866) 357-3304

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly high than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1(800) 499-8121. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-(866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-(877) 0267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Plan administrative office at 1 (800) 499-8121 or the Department of Labor's Employee Benefits Security Administration at 1 (866) 444-EBSA (3272) or www.dol.gov.ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care Help Center, 980 9th St, Suite 500, Sacramento, CA 9584 at 1 (888) 466-2219 or on the web at www.healthhelp.ca.gov or by email at helpline@dmhc.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Written translations are available in the following language within 7 business days by contracting plan representatives at the phone number below:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-(800) 533-0119.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,260**
- **Patient pays $ $1,280**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Co-pays	$20
Co-insurance	$1, 010
Limits or exclusions	$150
Total	**$1,280**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,360**
- **Patient pays $1,040**

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Co-pays	$400
Co-insurance	$460
Limits or exclusions	$80
Total	**$1,040**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

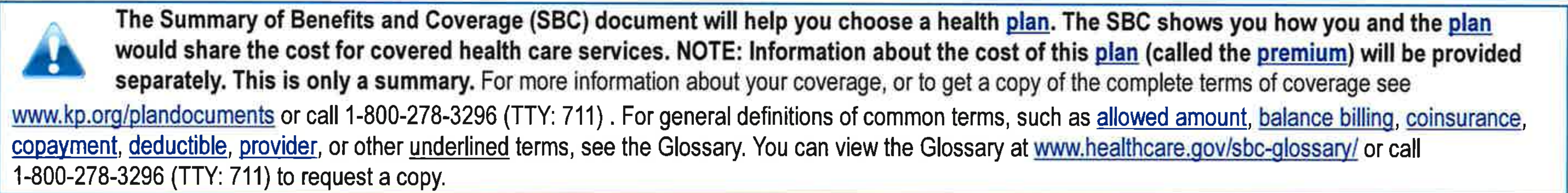
✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

KAISER PERMANENTE® : TRADITIONAL PLAN LAMBT Medium HMO

Coverage for: Individual/Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see 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 provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$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, MRI's)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs	$30 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$30 / 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	$100 / visit	$100 / 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)	$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: $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	$100 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	$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	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: $100 / admission; 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	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
- 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. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.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, 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** **$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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
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** **$15**
- **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:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

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** **$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:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

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理索賠／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 KaiserPermanente 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	Southern California
Civil Rights/ADA Coordinator	Civil Rights/ADA Coordinator
1800 Harrison St.	SCAL Compliance and Privacy
16th Floor	393 East Walnut St.,
Oakland, CA 94612	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: 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, ກະລຸນາໂທຣ **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’diitįįhgóó t’áá shọọdí koji’ hodíílnih **1-800-464-4000** áko saad bee áká i’iilyeed yídíkił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindįį’ 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, visit www.welcometouhc.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. Preventive care 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 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?	For participating providers $1,000 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?	Copayments for certain 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. See www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating 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 a non-participating 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 participating provider might use a non-participating 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, written or oral approval is required, based upon medical policies.	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.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	Non-Participating 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 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	$20 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	What You Will Pay Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com/uhcwest.	Tier 1 – Generic drugs	$10 copay / prescription retail $10 copay / prescription mail order	Not covered	Participating Provider 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 specialty drugs, 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 plan.
	Tier 2 – Preferred Brand drugs	$30 copay / prescription retail $30 copay / prescription mail order	Not covered	
	Tier 3 – Non-Preferred Brand drugs	$30 copay / prescription retail $30 copay / prescription mail order	Not covered	
	Tier 4 – Specialty drugs	Not applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Copayment waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 copay / visit	$75 copay / visit	If you receive services in addition to urgent care, additional copayments or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay / admit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	 Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay / 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 copay / admit	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments or coinsurance 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	
	Childbirth/delivery facility services	$100 copay / admit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$15 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	Not covered	Not covered	No coverage for Habilitative services.
	Skilled nursing care	$100 copay / admit	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	If inpatient admission, subject to inpatient copayments or coinsurance.
If your child needs dental or eye care	Children's eye exam	$15 copay / visit	Not covered	1 exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	No coverage for Dental check-ups.

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 are
- 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, kwiijigo 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** $20
- **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
What isn't covered	
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** $20
- **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
What isn't covered	
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** $20
- **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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 711 :TTY / 1-800-624-8822. وإذا احتجت لمزيد من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: 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 និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ 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 هزینهدریافت 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 1-800-624-8822/TTY: 711. 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 मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। 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 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る可能性があります。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
ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:
ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ 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 pagsasalin 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 คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ 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 được cung cấp 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.

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
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
Preventative & Diagnostic -		
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
Restorative -		
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]
Other -		
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
Preventative & Diagnostic -		
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
Restorative -		
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]
Other -		
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 6[1]**	**CIGNA[2]**
Annual Maximum	$ 1,500	None
Dental Preferred Provider	80%	Not applicable
Preventative & Diagnostic -		
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
Restorative -		
Amalgam, 1 Surface (Permanent)	$ 30.00	No charge
Amalgam, 2 Surfaces (Permanent)	40.00	No charge
Composite Resin, 1 Surface	40.00	No charge No charge
Crown, Porcelain with Metal	300.00	$60.00[4]
Other -		
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:

1. **Select a provider.** Select a participating vision care provider by visiting www.MESVision.com. Obtaining services from a Participating Provider will maximize your benefits.
2. **Make an appointment.** Call the Participating Provider of your choice to make an appointment and inform them of your vision coverage.
3. **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.
4. 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 MESV*ision*. 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 MESV*ision* 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 TLCVision for conventional and custom LASIK procedures with the TLCVision 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

Your Vision Benefits Summary

Get the best in eyecare and eyewear with LOS ANGELES MACHINISTS BENEFITS TRUST and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com.**
  Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.**
  The decision is yours to make—choose a VSP provider or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best EyeCare

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$5 for exam and glasses
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Combined with exam
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $105 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Primary Eyecare	
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam...up to $50
Frame...up to $70
Single Vision Lenses...up to $50
Lined Bifocal Lenses...up to $75
Lined Trifocal Lenses...up to $100
Progressive Lenses...up to $75
Contacts...up to $105

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change.

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Your Vision Benefits Summary

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That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$5 for exam and glasses
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Every 12 months	Combined with exam
Lens Enhancements	• Progressive lenses • Anti-reflective coating • Tints/Photochromic adaptive lenses • Polycarbonate lenses • Scratch-resistant coating • Average savings of 35-40% on other lens enhancements • Every 12 months	$0 $0 $0 $0 $0
Contacts (instead of glasses)	• $105 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Primary Eyecare	
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam....................up to $50
Frame....................up to $70
Single Vision Lenses....................up to $50
Lined Bifocal Lenses....................up to $75
Lined Trifocal Lenses....................up to $100
Progressive Lenses....................up to $75
Contacts....................up to $105

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

[1]Brand/Promotion subject to change.

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