



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.kp.org/plandocuments or call 1-800-278-3296. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-278-3296 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$150/individual or \$450/family. 01/01-12/31.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care <u>and services indicated in chart starting on page 2.</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000/individual or \$6,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, health care this plan does not cover & services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>plan providers</u> , see www.kp.org or call 1-800-278-3296.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, but you may self-refer to certain <u>specialists</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not covered	None
	Specialist visit	\$15 copay/visit	Not covered	Services related to infertility treatment covered at 50% coinsurance/visit.
	Preventive care/screening/immunization	No charge	Not covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay/encounter	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 copay/procedure	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	Plan pharmacy: \$10 copay /prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: \$20 copay /prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not covered	
	Non-preferred brand drugs	Same as preferred brand	Not covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$15 copay /visit	\$15 copay /visit	Non-Plan providers covered when outside the service area.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /office visit; 10% coinsurance for other outpatient services	Not covered	Mental/Behavioral Health: \$7 <u>copay</u> /group visit; Substance Abuse: \$5 <u>copay</u> /group visit
	Inpatient services	10% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per year.
	Rehabilitation services	Inpatient: 10% coinsurance; Outpatient: \$15 <u>copay</u> /visit	Not covered	None
	Habilitation services	\$15 <u>copay</u> /visit	Not covered	None
	Skilled nursing care	10% <u>coinsurance</u>	Not covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	10% <u>coinsurance</u>	Not covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice services	No charge	Not covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.
If your child needs dental or eye care	Children's eye exam	\$15 copay/visit	Not covered	May be covered under a separate vision <u>plan</u> .
	Children's glasses	Not covered	Not covered	May be covered under a separate vision <u>plan</u> .
	Children's dental check-up	Not covered	Not covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

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|-----------------------|------------------------------------------------------|------------------------------------------------|
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care unless medically necessary |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |
| • Long-term care | | |

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

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|----------------------------------------|----------------------------------------------------|----------------------------|
| • Acupuncture (plan provider referred) | • Chiropractic care (20 visit limit/year) | • Infertility treatment |
| • Bariatric surgery | • Hearing aids (\$1,000 limit/ear every 36 months) | • Routine eye care (Adult) |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or <http://www.HealthHelp.ca.gov>.

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

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

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 711.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 711.

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 or TTY/TDD 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	\$150
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	10%
■ Other (blood work) copayment	\$10

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,210

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$150
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	10%
■ Other (blood work) copayment	\$10

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$900
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$50
The total Joe would pay is	\$1,200

Mia's Simple Fracture

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

■ The plan's overall deductible	\$150
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other (blood work) copayment	\$10

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$350

The Laborers Health and Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language	Message about Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 707-864-2800.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 707-864-2800。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 707-864-2800.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 707-864-2800.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 707-864-2800. 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 707-864-2800.
Persian (Farsi)	رایگان به صورت زبانی توسط سه یلات کزید، می گفتم گو فارسی زبان به هرگاه: توجهت به گزیددت ماس باشد. بامی فراهم 707-864-2800 شما برای
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 707-864-2800.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。707-864-2800 まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 707-864-2800.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 707-864-2800. 'ਤੇ ਕਾਲ ਕਰੋ।
Mon-Khmer, Cambodian	ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 707-864-2800 ។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 707-864-2800.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 707-864-2800. पर कॉल कर_।
Thai	ความสนใจ: ถ้าคุณพูดภาษาไทย, บริการให้ความช่วยเหลือภาษาฟรีที่มีอยู่ โทร 707-864-2800.