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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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](http://www.kp.org/plandocuments) or call 1-800-278-3296. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/" \l "copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-278-3296 to request a copy. |

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| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **$150/**individual or **$450**/family. 01/01-12/31. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **Yes.** Preventive care and services indicated in chart starting on page 2. | 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**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | **No.** | You don’t have to meet deductibles for specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | **$3,000**/individual or **$6,000**/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**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | 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 out-of-pocket limit. |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | **Yes.** For a list of network providers, see [www.kp.org](http://www.kp.org) or call 1-800-278-3296 (TTY:711). | 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#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 the plan’s permission before you see the specialist. |

| **Exclamation** | All **[copayment](https://www.healthcare.gov/sbc-glossary/" \l "copayment)** and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $15 copay/visit | Not covered | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $15 copay/visit | Not covered | Services related to infertility treatment covered at 50% coinsurance/visit. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | $10 copay/encounter | Not covered | None |
| Imaging (CT/PET scans, MRIs) | 10% coinsurance | Not covered | None |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at www.kp.org/formulary | Generic drugs | Retail: $10 copay/prescription;  Mail order: $20 copay/prescription | Not covered | In accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| Preferred brand drugs | Retail: $20 copay/prescription;  Mail order: $40 copay/prescription | Not covered |
| Non-preferred brand drugs | Same as preferred brand | Not covered | Same as preferred brand drugs when approved through exception process. |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | 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](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 10% coinsurance | 10% coinsurance | None |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 10% coinsurance | 10% coinsurance | None |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $15 copay/visit | $15 copay/visit | Non-Plan providers covered when outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | None |
| Physician/surgeon fees | 10% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/office visit; 10% coinsurance for other outpatient services | Not covered | Mental/Behavioral Health: $7 copay/group visit;  Substance Abuse: $5 copay/group visit |
| Inpatient services | 10% coinsurance | 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 (e.g. ultrasound). |
| Childbirth/delivery professional services | 10% coinsurance | Not covered | None |
| Childbirth/delivery facility services | 10% coinsurance | Not covered | None |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Inpatient: 10% coinsurance; Outpatient: $15 copay/visit | Not covered | None |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | $15 copay/visit | Not covered | None |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 10% coinsurance | Not covered | Up to 100 days maximum per benefit period. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 10% coinsurance | Not covered | Must be in accordance with formulary guidelines. Requires prior authorization. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#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 plan. |
| Children’s glasses | Not covered | Not covered | May be covered under a separate vision plan. |
| 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**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Children’s glasses * Cosmetic surgery * Dental care (Adult & Child) | * Long-term care * Non-emergency care when traveling outside the U.S. * Private-duty nursing | * Routine foot care unless medically necessary * Weight loss programs |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Acupuncture (plan provider referred) * Bariatric surgery | * Chiropractic care (20 visit limit/year) * Hearing aids ($1,000 limit/ear every 36 months) | * Infertility treatment * Routine eye care (Adult) |

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

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

**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, kwiijigo 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.–––––––––––*–––––––––––

Exclamation

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/" \l "copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$150**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) **copayment $15**

◼ **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** |

**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**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$150**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#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**  **The plan would be responsible for the other costs of these EXAMPLE covered services.** |

**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**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$150**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#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** |

**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: Զանգահարեք 707-864-2800. |
| Persian (Farsi) | تتوجھ: اگر بھ زبان فارسی گفتگو می کنید، تسھیلات زبانی بصورت رایگان برای شما 707-864-2800 فراھم می باشد. با تماس بگیرید. |
| 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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. |