SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST

720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3674

ANNOUNCEMENT TO ALL PLAN PARTICIPANTS

ENCLOSED YOU WILL FIND YOUR OPEN ENROLLMENT MATERIAL FOR 2013. ENROLLMENT CHANGES ARE ACCEPTED IN JULY AND TAKE EFFECT AUGUST 1, 2013

The Trustees met on May 20, 2013, and approved increases to provider renewals **with no changes in benefits**. As of the Plan Year ended January 31, 2013, the Plan's uncommitted reserves were $17.15 million, representing an equivalent of 6.9 months of benefits and operating expenses, compared to uncommitted reserves of $15.29 million, representing 6.8 months of benefits and operating expenses for the Plan Year ended January 31, 2012. The $1.86 million increase in Plan assets as of the year end was due to a combination of factors including 1) a 10.2% investment return, 2) a 20% increase in reported hours, and 3) a $0.75 per hour increase to the employer contribution rate effective June 1, 2012.

In spite of the increase in Plan assets, the number of months of uncommitted reserves as of January 31, 2013 remained flat because of rising health care costs and additional liabilities due to an increase in enrollment as more employees returned to active employment. Although difficult to predict, with the $0.60 per hour increase to the contribution rate that took effect June 1, 2013, it is projected that the Plan's uncommitted reserves are sufficient to cover Plan expenses through the current Plan Year, assuming no decline in reported hours and modest investment returns. The Board of Trustees will continue to monitor the Plan and take action, as necessary, to ensure that the Plan remains healthy.

New COBRA Rates

The Plan's COBRA rate is the lesser of 1) the calculated rate based on the applicable premiums plus a 2% administrative charge, and 2) the hourly employer Plan contribution rate, multiplied by the number of hours required for one month of Plan coverage. The following table, reflects the Active Plan COBRA rates that will apply for coverage beginning August 1, 2013 and ending July 31, 2014:

Plan	Medical Only	Medical, Dental & Vision
Self Funded PPO Plan	$1,150.49	$1,311.07
Kaiser Plan	$1,132.55	$1,293.12
Blue Shield HMO	$1,530.00	$1,690.58

If you have any questions regarding the change in benefits described above, please contact EISB at (415) 263-3670.

SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST

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2013-2014 OPEN ENROLLMENT NOTICE

July 2013

TO: SAN FRANCISCO ELECTRICAL WORKERS RETIREE PLAN PARTICIPANTS

FROM: BOARD OF TRUSTEES

RE: OPEN ENROLLMENT- Plan selection for 8/1/2013 – 7/31/2014

The Open Enrollment is being held during the month of July for coverage effective August 1, 2013. **Depending on where you reside,** you may choose from the following medical plans:

- **SELF FUNDED PPO**
- **KAISER or KAISER SENIOR ADVANTAGE HMO**
- **BLUE SHIELD HMO**

A comparison of the more significant benefits along with the Summary of Benefits Coverage for each medical plan as required by the Affordable Care Act and the current monthly co-payment schedule are enclosed. You are urged to study this comparison carefully and select the Plan you feel best meets the needs of your family. **Note that only under special circumstances, will participants be allowed to change plans outside the open enrollment period. This is why it is important for you to review all of the information before you make a change.** You may also contact the Fund Office if you would like additional information regarding the Plans.

If you wish to remain under your present coverage, no action is required.

If you are changing coverage, complete the enclosed Request Form and return it to the Plan Office immediately. ALL CHANGE APPLICATIONS MUST BE RECEIVED NO LATER THAN July 26, 2013.

REMINDER: All Members who are eligible for Medicare must sign up for both Parts A (Hospital) and B (other medical) of Medicare. If you are in the Self Funded PPO Plan, your claims will be processed as though you are covered by Medicare, even if you fail to sign up or you are treated by a non-Medicare certified provider. Medicare eligible retirees or dependents who elect Kaiser but do not enroll in Kaiser Senior Advantage will be charged the difference between the premium for the Senior Advantage Plan and the amount charged to the Trust.

Continued on Other Side

Medicare-eligible Retirees are reminded not to enroll in a separate Medicare Part D prescription program outside of the plan. The prescription drug benefit you currently receive under the Plan (whether Indemnity Plan or Kaiser Senior Advantage) provides better coverage, at less cost to you, than other Medicare Part D programs. As long as you are eligible to have prescription drug coverage through the Plan, you are considered to have "Creditable Coverage"; therefore, if at some later date you choose to enroll in Medicare Part D outside this plan, you will not be charged a late penalty for delayed enrollment.

Please note that while the Plan advises you NOT to enroll in Medicare Part D outside the plan, you must still enroll for both Medicare Part A and Part B to be eligible for full coverage.

If you have any questions concerning this information or require additional information, do not hesitate to contact the Plan Office at (415) 263-3670.

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2013-2014 HEALTH MAINTENANCE ORGANIZATIONS COMPARISON OF BENEFITS SUMMARY

PRINCIPAL FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare Advantage Plan)	BLUE SHIELD HMO NON MEDICARE
CHOICE OF PROVIDERS	Must use Kaiser facilities and providers	Must use Kaiser facilities and providers	Must use Health Plan provider
PLAN MAXIMUMS	No plan maximum	No plan maximum	No plan maximums.
OUT OF POCKET MAXIMUMS	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$2,000 individual $4,000 two-party $6,000 family
HOSPITAL CONFINEMENT *Room and board, surgery, anesthesia and miscellaneous*	No charge	No charge	$100 per confinement
DOCTOR VISITS Office Hospital	$20 per visit No charge	$20 per visit No charge	$25 per visit No charge
OUTPATIENT LAB & X-RAYS	No charge	No charge	No charge
OUTPATIENT SURGERY	$20 per procedure	$20 per procedure	$50 per surgery
PREVENTIVE HEALTH CARE *(All preventive screenings mandated by the Affordable Care Act).*	No Charge	No Charge	No Charge
AMBULANCE SERVICES	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.	No charge
MATERNITY CARE Mother's Expenses Newborn Care	 No charge Inpatient Care $5 Prenatal Care & First postpartum office visit No charge in hospital. **Newborns must be enrolled within 31 days of birth.**	 No charge Inpatient Care $5 Prenatal Care and First postpartum office visit No charge in hospital. **Newborns must be enrolled within 31 days of birth.**	 Inpatient: $100 Co-pay Pre/Post Natal Care- No charge. No charge in hospital. **Newborns must be enrolled within 31 days of birth.**
EYE EXAMINATIONS/GLASSES **Vision Service Plan:** $10 co-payment Examinations: every 12 months Lenses: every 12 months Frames: every 24 months	Covered through Vision Service Plan. $20 co-payment eye examinations only through Kaiser.	Covered through Vision Service Plan. $20 co-payment for examinations Kaiser provides $150 eyewear allowance for one pair every 24 months. Contacts in lieu of glasses if medically necessary.	Covered through Vision Service Plan.
MENTAL HEALTH	Outpatient: $20 co-pay for individual visits. $10 co-pay for group visits. Inpatient: Hospital covered in full.	Outpatient: $20 co-pay for individual visits. $10 co-pay for group visits. Inpatient: Hospital covered in full.	Outpatient: $0 Co-pay In Patient: $0 Co-pay

PRINCIPAL FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare Advantage Plan	BLUE SHIELD HMO NON MEDICARE
SUBSTANCE ABUSE TREATMENT (*Alcohol or drug abuse)*	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits	Outpatient: $0 Co-pay In Patient $0 Co-pay
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Not Available	Not Available	Life Referrals (800) 985-2409; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice; Eldercare, etc.
PHYSICAL THERAPY	$20 co-payment (short term)	$20 co-payment (short term)	$25 per visit (short term)
PRESCRIPTION DRUGS	$10 (generic) $30 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. $20 (generic) $60 (brand named) per prescription or refill for a 90 day supply of mail order only.	$10 (generic) $25 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. $20 (generic) $60 (brand named) per prescription or refill for a 90 day supply of mail order only.	$15 (generic) $30 (brand named) per prescription or refill for a 30-day supply. $30 (generic) $60 (brand named) per prescription or refill for a 90-day supply of mail order prescriptions. Home Self-injectable 20% up to $100 co-pay maximum per prescription
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	No Charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	No Charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	Prosthetic & Orthotic – equipment & devices no charge with authorization. Durable Medical Equipment- no charge
EMERGENCY CARE AND OUT OF SERVICE AREA (*Outside of Plan facilities*)	$100 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	$50 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	$100 co-pay, waived if admitted. Routine care not covered.
DENTAL COVERAGE	Covered by Delta Dental.	Covered by Delta Dental	Covered by Delta Dental
SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Natural/Step/Adopted Children through age 18; Adult Children ages 19 through 25.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/ 100 days per benefit period no charge if authorized.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/100 days per benefit period no charge if authorized.	Allergy testing: $25 co-pay for allergy testing, serum included. Chiropractic: Chiropractic and Acupuncture services not covered. Facility: Skilled nursing/100 days per year no charge if authorized. Infertility treatment:: Diagnosis and treatment of Causes of Infertility paid at 50% of allowed charges.(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) Home health care: Maximum of 100 days per calendar year.

NOTE: This comparison of benefit coverage is intended only as a general description of the principal features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2013-2014 COMPREHENSIVE MEDICAL BENEFITS SUMMARY

PRINCIPAL FEATURES	SELF FUNDED PPO PLAN
CHOICE OF PROVIDERS	Choose any physician. Choose a PPO Physician/Hospital to receive maximum benefits.
PLAN MAXIMUMS (Per Calendar Year Per Family Member)	$2,000,000 effective 1/1/2013; No annual maximum effective 1/1/2014
BENEFITS/OUT OF POCKET MAXIMUMS	In Network Providers: All benefits paid at 80% of the PPO Contract Rate after satisfying deductible of $150 per person/$300 family. All covered benefits paid at 100% of the PPO Contract Rate after incurring $1,500 per person in "out of pocket" covered expenses in a calendar year. Out of Network Providers: All benefits paid at 60% of usual and customary charges after satisfying deductible of $150 per person/$300 family. All covered benefits paid at 80% of usual and customary charges after incurring $1,500 per person in "out of pocket" covered expenses in a calendar year.
HOSPITAL CONFINEMENT *(Room and board, surgery, anesthesia and miscellaneous)*	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**
DOCTOR VISITS – Office/Hospital	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**
OUTPATIENT LAB & X-RAYS	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**
OUTPATIENT SURGICAL & EMERGENCY ROOM SVCS	First $5,000 paid at 100% (in network), 80% (Out of network) ; After first $5,000, See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**
PREVENTIVE TREATMENT SERVICES FOR ADULTS, WOMEN, AND CHILDREN	**100 % coverage for preventive care treatment, as required under PPACA. Information regarding services that are covered is available at: http://www.healthcare.gov/law/about/provisions/services/lists.html**
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice, Eldercare, etc.
AMBULANCE SERVICES	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**; payable if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.
MATERNITY CARE Mother/Newborn Hospital Expenses Newborn Care	(Members and Spouses/Domestic Partners only) See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums** Same as hospital confinement coverage shown above, for 48 hours following normal vaginal delivery and 96 hours following delivery by caesarian section. Well Baby covered while mother is confined
EYE EXAMINATIONS/GLASSES	Covered through Vision Service Plan; $10 co-payment; examination and lenses available every 12 months; new frames available every 24 months.
MENTAL HEALTH /SUBSTANCE ABUSE TREATMENT .	In Network: 100% of the PPO Contract Rate; See Benefits for Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**.
PHYSICAL THERAPY	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**; Services subject to medical review for determination of medical necessity and appropriate treatment frequency.
PRESCRIPTION DRUGS	Effective 8/1/2012 administered through Catamaran. Individual responsible for 20% co-payment (maximum co-pay for generics of $7 retail and $17.50 mail order) payable to pharmacy at time prescription is filled. For certain select drugs prescribed after 8/1/2012, Step therapy program requires purchase of lower cost medication before trying a brand drug; otherwise, participant will be required to pay the applicable copay plus the total cost difference between the brand and the alternative, unless clinical documentation from the prescribing physician indicates the lower cost medication is not a suitable substitute.
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**; Rental of durable medical equipment, not to exceed the purchase price
EMERGENCY CARE AND OUT OF SERVICE AREA **(***Outside of Plan facilities***)**	Coverage applies worldwide. Charges for certain emergency related treatment is covered under the $5,000 Out Patient Surgical & Emergency Room SVCS described above
DENTAL COVERAGE	This is a self-funded dental program administered by Delta Dental. Separate brochure/summary is available.
SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Natural/Step/Adopted Children, Children of Registered Domestic Partner through age 18; Adult Children ages 19 through 25	Chiropractic & Acupuncture treatments covered as any other medical expense, limited to 30 visits per calendar year. Self-Funded PPO Plan payments are based on allowable charges. Blood donations for your own surgery covered if physician recommends.
MEDICARE ELIGIBLE RETIREES AND DEPENDENTS The Plan will offset covered charges by the amount payable by Medicare, even if a Medicare eligible retiree or dependent fails to enroll or is treated by a non-Medicare certified provider.	

NOTE: This comparison of benefit coverage is intended only as a general description of the principal features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

San Francisco Electrical Workers Health & Welfare Plan

RETIREE MONTHLY COPAY RATES FOR 2/2013-1/2014

Early Retirees (Age 62-64) who will reach Full Retiree Membership status at age 65*	
Plan	**Monthly Payment Effective 2/1/2013**
Kaiser-Single	**651.00**
Kaiser-Family	**976.00**
Blue Shield (HMO)-Single	**675.00**
Blue Shield (HMO)-Family	**1,012.00**
Self Funded Plan (PPO)-Single	**875.00**
Self Funded Plan (PPO)-Family	**1,312.00**

*Full Retiree Status at age 65: Under age 59 at the time hourbank runs out following retirement.

Early Retirees (Age 62-64) who will reach Full Retiree Membership status at age 62**	
Plan	**Monthly Payment Effective 2/1/2013**
Kaiser	**530.00**
Blue Shield (HMO)	**530.00**
Self Funded Plan (PPO)	**530.00**

**Full Retiree Status at age 62: Age 59 or older at the time hourbank runs out following retirement.

Other Retiree Categories		
Plan	**New Monthly Payment Effective 2/1/2013**	
Surviving Spouses and Under Age 65 Disabled Retirees		**460.00**
Over Age 65 retirees who attained, or will attain, age 75 on or after 1/1/2007	**Single** **Family**	**200.00** **400.00**
Retirees who attained Age 75 before 1/1/2007		**0.00**

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST
720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670

PLAN and DEPENDENT CHANGE REQUEST FORM

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.)

Non-Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)
- ☐ BLUE SHIELD HMO (Limited to certain geographic areas in California Only - contact Plan Office for more information or the Blue Shield website @ www.blueshieldca.com).

Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER SENIOR ADVANTAGE (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)

If you have had a change in dependent status or wish to add an eligible dependent not currently enrolled in the Plan, please check the applicable box below and Plan Office will send you a Beneficiary Form:

- ☐ CHANGE IN DEPENDENT STATUS

_____
Your Name (please print)

_____
Signature

_____
Social Security Number

_____
Street Address

_____
City, State, Zip Code

[Attached is a schedule showing the monthly co-payment rates for February 1, 2012 through January 31, 2013.]

ANNUAL NOTICE
[This information is included in your Summary Plan Description]

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, President Clinton Signed the Omnibus Appropriations Bill which included a new federal law called the Women's Health and Cancer Rights Act of 1998. Under this new federal law, group health plans, 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 on the other breast to produce a symmetrical appearance, and 3) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the plan's annual deductibles and coinsurance provisions.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connections with childbirth for the mother or newborn child less than 48 hours following a normal 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 her newborn earlier than the 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).

If you have any questions concerning these matters, please contact the Fund Office at (415) 263-3670.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.kp.org** or by calling **800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See Chart on Page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $1,500** person / **$3,000** family	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, payments for health care this plan doesn't cover and cost sharing for certain services listed in plan documents.	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.** For a list of **plan providers**, see **www.kp.org** or call **800-278-3296**.	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 term in-network, **preferred**, or participating for **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?	**Yes**, written referral required 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**.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	Not Covered	——————none——————
	Specialist visit	$20 per visit	Not Covered	Services related to Infertility covered at $20 per visit
	Other practitioner office visit	$15 per visit for chiropractic services, $20 per visit for acupuncture services.	Not Covered	Up to 30 visit(s) per Calendar Year for chiropractic services, Physician referred acupuncture.
	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)	No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
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	Retail:$10 per prescription for 1 to 30 day(s) ; Mail Order:Usually two times the retail cost sharing for up to a 100 day supply	Not Covered	Retail: $20 per prescription for 31 to 60 day(s) ,$30 per prescription for 61 to 100 day(s).Certain drugs may be covered at a higher cost share.
	Preferred brand drugs	Retail:$30 per prescription for 1 to 30 day(s) ; Mail Order:Usually two times the retail cost sharing for up to a 100 day supply	Not Covered	Retail: $60 per prescription for 31 to 60 day(s) ,$90 per prescription for 61 to 100 day(s).Certain drugs may be covered at a higher cost share.
	Non-preferred brand drugs	$30 per prescription for 1 to 30 day(s)	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	$30 per prescription for 1 to 30 day(s)	Not Covered	Same as preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 per procedure	Not Covered	——————none——————
	Physician/surgeon fees	No Charge	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$100 per visit	$100 per visit	——————none——————
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$20 per visit	$20 per visit	Non plan providers covered when outside a service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	——————none——————
	Physician/surgeon fee	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per visit for Individual, $10 per visit for Group	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$20 per visit Individual, $5 per visit Group	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge, Postnatal care: No Charge	Not Covered	Cost sharing for prenatal care is for routine preventive care only. Cost sharing for postnatal care is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hour(s) Maximum per Visit ,Up to 100 visit(s) Maximum per Calendar Year ,Up to 3 visit(s) Maximum per Day
	Rehabilitation services	Inpatient:No Charge; Outpatient:$20 per day	Not Covered	——————none——————
	Habilitation services	$20 per day	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 day maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

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.)**

- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care when Travelling Outside the U.S.
- Private-Duty Nursing
- Routine Dental Services (Adult)
- Weight Loss Programs

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.)**

- Acupuncture with limits
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Exam (Adult)
- Routine Foot Care
- Routine Hearing Tests

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 higher 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 800-278-3296. 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 1-877-267-2323 x61565 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: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the California Department of Insurance at or 1-800-927-HELP (4357) or http://www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact: California Department of Insurance at or 1-800-927-HELP (4357) or http://www.insurance.ca.gov.

Additionally, a consumer assistance program can help you file your appeal.

Department of Managed Health Care Help Center	(888) 466-2219
980 9th Street, Suite 500	http://www.healthhelp.ca.gov
Sacramento, CA 95814	helpline@dmhc.ca.gov

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE: 若有問題：請撥打 1-800-757-7585 或 TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-278-3296 or TTY/TDD 1-800-777-1370

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** $7,320
- **Patient pays** $220

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	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

Prescriptions	$2,900
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	$0
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$780**

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.