Employee Benefits 2019-2020

Active Employees and Retiree Benefits Overview

(Effective February 1, 2019 – January 31, 2020)

HEALTH INSURANCE

Eligibility

- Full-time employees
- Part-time employees who worked an average of thirty (30) hours or more per week over the last twelve (12) months of service
- Retirees eligible for Post-Retirement Health Insurance Coverage

Health Plans

1. **City Self-Insured PPO Plan**
   The PPO Plan offers health benefits including medical, dental, vision and prescription coverage. The PPO Plan offers you access to a large network of physicians who agree to discount their fees for service. Under this plan, you are not required to select a Primary Care Physician and you can access different physicians and specialists at your own discretion. While you may go to any doctor or hospital each time you need care, your co-pay or coinsurance will be lowest when you go to an in-network PPO provider. If you use providers who participate in the network, your care will be covered at the highest benefit level for most services after your deductible is met.

2. **Kaiser HMO Plan**
   The Kaiser HMO Plan offers health benefits including medical, vision and prescription coverage. The dental benefit is augmented through the Dental PPO Plan. When you enroll in the Kaiser HMO Plan, you agree to use only Kaiser doctors and facilities for all your medical care. Kaiser covers most services at 100%, with no deductible. Most office visit co-payments are $25. Emergency room services require a $100 co-payment per visit. This co-payment is waived if you are admitted to the hospital. Members who travel out of state to a region with Kaiser presence are covered for full services. Otherwise, members are covered for urgent and emergency care only. Kaiser regions include covered zip codes in Hawaii, Washington, Oregon, Colorado, Maryland, Georgia, Virginia and Washington DC.

   Please note retirees are not eligible to remain on the Kaiser HMO Plan if they permanently move outside of Southern California. The contract in place is for the Southern California region only.

3. **Premium Split Option ("PSO")**
   Under the PSO, an employee will be reimbursed $583.40 per month for waiving out of health insurance. **This option is only available during Open Enrollment to full-time employees who were enrolled in the PSO as of December 31, 2017.**

Employee Benefits 2019-2020

COST OF COVERAGE

Full-Time Employees and Retirees
The City will contribute up to the cost for two-party coverage at $1,166.79 per month. The family coverage co-pay will remain at $494.00 per month.

Please remember that the health insurance coverage for retirees is the same as the coverage for active employees, including premium rates. Any changes in cost will be subject to the terms of the collective bargaining agreement in effect at the time of retirement.

2018 RATES (PPO PLAN)	
Single	$ 583.00/month
Two-Party	$ 1,166.79/month
Family	$ 1,660.79/month

2019 RATES (PPO PLAN)	
Single	$ 583.00/month
Two-Party	$ 1,166.79/month
Family	$ 1,660.79/month

2019 RATES (KAISER HMO PLAN)	
Single	$ 575.19/month
Two-Party	$ 1,150.37/month
Family	$ 1,627.78/month

Part-Time Employees
All plans will be provided at full cost to the part-time employee upon eligibility.

2018 RATES (PPO PLAN)	
Single	$ 110.00/month
Two-Party	$ 670.00/month
Family	$ 1,104.00/month

2019 RATES (PPO PLAN)	
Single	$ 125.00/month
Two-Party	$ 1,166.79/month
Family	$ 1,660.79/month

2019 RATES (KAISER HMO PLAN)	
Single	$ 575.19/month
Two-Party	$ 1,150.37/month
Family	$ 1,627.78/month

Employee Benefits 2019-2020

MEDICAL BENEFITS SUMMARY

City Self-Insured PPO Plan
Please refer to attached Summary of Benefits and Coverage.

Kaiser HMO Plan
Please refer to attached Summary of Benefits and Coverage.

DENTAL BENEFITS SUMMARY – DENTAL PPO

Please contact the Human Resources Office if you need assistance finding a dental provider.

Calendar Year Deductible	$50.00 Individual / $150.00 Family
Calendar Year Benefit Maximum	$1,500.00 per person
Preventive Services*	Plan pays 100%, no deductible
Basic Services*	Plan pays 80% after deductible
Major Services*	Plan pays 50% after deductible
Orthodontia	Plan pays 80% after deductible
Orthodontia Lifetime Maximum	$1,000.00

* Please see City Plan Document for more information and exclusions.

VISION BENEFITS SUMMARY – MES (MEDICAL EYE SERVICE) VISION

To find a MES Provider or look up your eligibility or claims, you can call (800) 877-6372 or visit website www.MESVision.com.

Vision Examination	$25.00 co-pay	Every 12 months
Frame	Up to $125.00 allowance	Every 24 months
Progressive Lenses*	Up to $89.50 allowance	Every 24 months
Contact Lenses*		
Medically necessary	Covered	Every 24 months
Cosmetic	Up to $125.00 allowance	Every 24 months

* Please see City Plan Document for more information and exclusions.

Employee Benefits 2019-2020

HEALTH INSURANCE CONTACT INFORMATION

Human Resources Contact

Nora Verceles, HR Manager
Phone: (310) 217-9509
Email: nverceles@cityofgardena.org

Diana Schnur, HR Analyst
Phone: (310) 217-9586
Email: dschnur@cityofgardena.org

Abigail Quiroz, HR Administrative Aide
Phone: (310) 965-2337
Email: aquiroz@cityofgardena.org

Erin Jackson, HR Technician
Phone: (310) 965-2324
Email: erinjackson@cityofgardena.org

Advanced Benefit Solutions ("ABS") **Group #AZ000048**
Third-Party Administrator – Indemnity/PPO Plan and Dental PPO

Mail claim forms to: P.O. Box 71490
Phoenix, Arizona 85050

Phone: (623) 889-7200 or (888) 419-1094 (Main Line)
Fax: (623) 889-7299
Website: www.absaz.net

Kaiser HMO Plan **Group #114189**
Dental Plan is offered through the Dental PPO ("DPPO") Plan

Member Services (800) 464-4000
Spanish (800) 788-0616

Medicare Members (800) 443-0815
Website: www.kp.org/thrive

Prescriptions – Envolve Pharmacy Solutions **Rx Group: 17080 / Rx BIN: 008019**
5 River Park Place East, Suite 210
Fresno, California 93720

Phone: (800) 460-8988
Website: www.envolverx.com

Prescriptions – Homescripts (Mail Order Services)
500 Kirts Boulevard
Troy, Michigan 48084

Phone: (888) 239-7690
Fax: (877) 396-5970

MES - Medical Eye Service (PPO Plan Only)
Mail claim forms to: P.O. Box 25209
Santa Ana, California 92799

Phone: (800) 877-6372
Website: www.MESVision.com

Employee Benefits 2019-2020

GROUP TERM LIFE AND AD&D INSURANCE

All permanent full-time employees are enrolled in the City paid Group Term Life and Accidental Death and Dismemberment Insurance as follows:

	GMEA	GMEO	GPOA
Coverage through City Health Plan*	$20,000.00	$20,000.00	$10,000.00
Coverage through AXA Employee Benefits Group	$20,000.00	1.5 times annual salary	Not applicable

* Employees who are enrolled in the Premium Split Option or waived medical insurance coverage is not eligible to receive Group Term Life and AD&D Insurance through the City Health Plan.

You may elect to purchase a Dependent Group Life Insurance policy in the amount of $3,000.00 for each dependent for a flat rate of $1.00 per month.

FLEXIBLE SPENDING ACCOUNT ("FSA")

You may contribute up to $2,700.00 on a pre-tax basis during Calendar Year 2019 to a health care reimbursement flexible spending account to pay for health care costs that are not covered by your medical, dental and vision insurance. For Plan Year 2018, you have until **February 28, 2019** to submit all eligible expenses. Reimbursement requests will be processed twice per month to coincide with approval of warrant requests by the City Council.

EMPLOYEE ASSISTANCE PROGRAM ("EAP") – REACH

The City provides an employee assistance program, administered by REACH, to all employees and their eligible dependents. REACH offers a completely confidential counseling and referral service for issues that may affect your personal life or job performance. The first three (3) sessions are paid by the City. If you need further assistance, you can arrange any additional sessions with REACH at cost to the employee.

To access REACH, call (800) 273-5273 or visit www.reachline.com.

ATTACHMENT 1
CITY SELF-INSURED PPO PLAN

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, call Advanced Benefit Solutions at toll-free **1-888-419-1094**. 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 by calling **1-888-419-1094** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: $500/Individual or $1,500/Family Non-Network Provider: $2,000/Individual or $6,000/Family	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?	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 per individual; for out-of-network providers unlimited.	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 and deductibles 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. For participating provider listing, see www.anthem.com/ca	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?	No. You do not need a referral to see a specialist.	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		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 physician office visit	$15 copay/office visit Pediatrician, OB/GYN; deductible waived. $25 copay/office visit General or Family Practice, Internist; deductible waived	40% coinsurance	Copay applies to all services at all physician office visits and billed by physician's office. Deductible waived for In-network provider.
	Specialist visit	$40 copay/visit	40% coinsurance	You may have to pay for services that aren't preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
	Preventive care/screening/ Immunization	No charge	40% coinsurance	
	Allergy Injections	$40 copay	40% coinsurance	
If you have a test	Diagnostic X-rays & Lab Inpatient or Outpatient*	20% coinsurance	40% coinsurance	*Except those performed in a network provider physician's office.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://pharmacy.envolvehealth.com	Generic drugs (Tier 1)	$15 copay/prescription Retail pharmacy $50 copay/prescription Mail order pharmacy	Not covered.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). $2,500 maximum benefit per covered drug.
	Preferred brand drugs (Tier 2)	$30 copay/prescription Retail pharmacy $100 copay/prescription Mail Order pharmacy	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care-illness Emergency room care-injury	$100 copay 20% coinsurance	$100 copay 20% coinsurance	Copay waived if immediately admitted directly into hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance Deductible waived.	40% coinsurance	None.

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)	$250 copay and 20% coinsurance. Deductible waived.	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
	Anesthesia	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	Deductible waived for In-network provider. *Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Inpatient services*	$250 copay and 20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$15 copay	40% coinsurance	*Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services*	$250 copay and 20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Acupuncture	50% coinsurance Deductible waived	50% coinsurance	Limited to $30 maximum benefit per visit/20 visits maximum benefit/calendar year.
	Chiropractic care	50% coinsurance Deductible waived	50% coinsurance	Limited to 20 visits/calendar year.
	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits/calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	See your plan document for additional benefits information and limitations.
	Chemotherapy/Radiation	20% coinsurance	40% coinsurance	None.
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you need dental or eye care	Dental services	$1,500 maximum benefit per calendar year.		Refer to your plan document for details.
	Eye care services	Provided through MES Vision		Benefits coverage list available at Human Resources Department.

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.)		
• Cosmetic Surgery	• Long Term Care	• Routine eye care (Adult)
• Infertility Treatment	• Non-emergency care when traveling outside the U.S.	• Weight Loss Programs
• Private Duty Nursing		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes)	• Chiropractic Care	• Podiatry
• Bariatric Surgery	• Hearing Aids	

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: 1-888-419-1094.

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 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 1-888-419-1094

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	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

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: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

ATTACHMENT 2
KAISER HMO PLAN

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 providers 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	$25 / visit	Not Covered	None
	Specialist visit	$25 / 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 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, 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, deductible does not apply.
	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, deductible does not apply.
	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)	$25 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$25 / visit	$25 / visit	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: $25 / individual visit. No Charge for other outpatient services; Substance Abuse: $25 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: $12 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	No Charge	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	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 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: No Charge; Outpatient: $25 / visit	Not Covered	None
	Habilitation services	$25 / 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	Limited to base-covered items in accordance with formulary guidelines. 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 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

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 (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	$25
Hospital (facility) copayment	$0
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	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$0
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	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

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

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

Total Example Cost	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copays	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$500**

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

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