**QUESTION AND ANSWER FORM**

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **1** | Is there an incumbent currently providing these services? | | Yes. |
| **2** | Are the services in this RFP continually needed, even beyond the term of the resulting contract, and therefore may be bid out again? | | Yes, the services are continuously needed into the foreseeable future. |
| **3** | Please provide Event ID # for the Cal eProcure website.<br>a. Please confirm if this site will be where to find any Addenda or if any Addenda will be distributed via email from the Court. | | This RFP was not posted in the Cal eProcure website. |
| **4** | Please confirm that Attachment 12 is the only document/location in the RFP response to be completed for references. | | Yes. |
| **5** | It is our understanding that State Community College Districts and K-12 school districts will meet the definition of public ageny (i.e. and any other agency of the state for the local performance of governmental or proprietary functions within limited boundaries). Please confirm. | | Yes. They meet the definition of a public agency. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **6** | Section 2.3 (GG): Please identify the Court's source selection committee. | | The evaluation panel will consist of subject matter experts from the Human Resources Division. |
| **7** | Section 2.3(HH):<br>a. Please clarify if it is the Court's intent to have the broker/consultant pay for wellness services or if it is a cost the Court will pay independently with the broker/consultant sourcing and overseeing the program.<br>b. Will the Court appoint a staff member(s) who will be directly responsible for the wellness program? | | a. The Court does not necessarily expect the broker to pay for the wellness services, however, we would like to see the broker work to negotiate wellness grants from our benefits vendors should they be available, then oversee the wellness program. Should there not be available funding sources outside of the Court, the Court may decide to contribute to the funding of a wellness program should the Court have the funding available.<br>b. The Court will appoint court staff to support the oversight of any wellness program agreed to by the Court. |
| **8** | Section 2.4 (E): With the Court being approximately 700 employees, should the response be targeting 1000 or greater employees or of more similar size to the Court? | | Section 2.4 (E) has been amended to 600 employees. See Addendum 1. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **9** | Section 6.2 and 6.3: Please clarify:<br>a. In Sections 6.2 (A) and (B), the Court requests hard copies of the RFP response. In Section 6.3, it states the proposal can be submitted via email. Which is the preferred method of delivery?<br>b. In Section 6.2 (C): The Court has requested the proposal on a stick/flash drive. Please confirm this is still required.<br>c. If email is the preferred method of delivery, please confirm if the technical and cost proposals should be sent separately or together.<br>d. If email is the preferred method of delivery, please confirm the correct email is bidquestions@alameda.courts.ca.gov | | a. There is no preferred method of delivery. Proposals can be sent through either method as long as the Court receives them by 3:00 PM on October 1, 2020.<br>b. The stick/ flash drive is required if hard copy proposals are submitted.<br>c. The proposals can be emailed together as separate attachments.<br>d. Yes, that is the correct submission email address. |
| **10** | Section 7.1(D): The request is for client references of 1000 or more employees. However, Section 2.2 indicates references should be at least 600 employees. Is there a preference? | | Section 2.2 (A)(i) and Section 7.1 (D) have both been amended to 600 employees. See Addendum 1 |
| **11** | Has the members of the evaluation team been identified? If so, will all evaluators be Court employees? If so, how many evaluators are appointed? Assuming more than one evaluator, will an average of the scores be utilized? | | Yes. The evaluation panel will consist of subject matter experts from the Human Resources Division.<br>and an average score will be utilized. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **12** | Section 7.0 (F)(v.): Are there other forms of acceptance than those listed? I do not find any other options listed in the jbcl manual. Would it be acceptable to have a statement from our CFO or other documentation? | | Proposers may submit any documentation they feel will prove financial solvency and stability. |
| **13** | Are you satisfied with the services and relationship with your current Broker/Consultant? | | Yes. |
| **14** | If you are satisfied with your current Broker/Consultant, why is the Court going through the RFP process at this time? | | The Court is required to go out to bid on services per the judicial branch procurement rules. |
| **15** | Please list your top four benefits objectives for the Court.<br>a. Are there any specific benefits services or benefits technologies the Court is interested in to achieve those objectives? | | 1. Reasonable and affordable benefits premium rates for our employees<br>2. A good array of benefit provider selections for Court employees to choose from<br>3. Reliable, resourceful and expert-level support from our benefits broker<br>4. Benefits plan design consistent with our current plan levels<br>a. Not at this time. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **16** | What are the top four qualities and areas of expertise you value most in working with a Broker/Consultant ? | | 1. Resourcefulness – the ability to procure the best rates and plan designs in support of the overall health of our employees.<br>2. Reliability – maintaining consistency in broker personnel, performance and levels of service.<br>3. Communication – transparent, informed and reliable communication with the Court, our vendors, our union partners as needed, with strong marketing communication in support of open enrolment.<br>4. Expertise – expert knowledge of the market to bring the best benefits options to our court, and access to legal expertise that provides sound guidance in support of any legislative changes pertaining to benefits administration. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **17** | Please list the names of the bargaining groups represented and how many employees are with each group.<br>a. What are the dates for each group for contract renewal? | | 1. ACMEA – Alameda County Management Employees Association<br>2. ACOCRA – Alameda County Official Court Reporters Association<br>3. CFI – California Federation of Interpreters<br>4. SEIU Local 1021 |
| **18** | What is your current employer contribution for Medical, Dental, Vision, EAP and Life plans? | | See attached Benefit Cost rate table |
| **19** | For the Court medical contribution, please advise the carrier that is currently providing the lowest cost plan. | | Sutter Health Plus |
| **20** | Please provide the Summary of Benefits Comparisons (SBCs) for all Medical, Dental, Vision, Life, Voluntary Short Term, Voluntary Long Term Disability and EAP plans including any plans offered by any of the Court's bargaining units. | | See attachments |
| **21** | What are the current 2020 Premium Rates, Court contribution and the Employee share for the Medical, Dental, Vision, EAP and Life/AD&D plans? | | See attached Benefit Cost rate table |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **22** | What are the 2021 Renewal Rates and Court contribution for the Employees' share for Medical, Dental, Vision, Life and AD&D plans?<br>a. If this is unknown, what is the budget for the increase or projected increase?<br>b. What are the 2021 plan design changes proposed for your Medical, Dental, Vision, EAP and Life plans? | | See attached Benefit Cost rate table. There are no Plan design changes for 2021.<br>The Union plans (Operating Engineers) pending. |
| **23** | What is the current enrolment for all plans by tier? Specifically, how many in each plan are enrolled as Employee only, Employee plus One Dependent and Employee plus Family Medical? | | See attachment Plans by Tier Level |
| **24** | What are the total annual premiums for Medical, Dental, Vision, Life, Voluntary Short Term Disability, Voluntary Long Term Disability and EAP plans? | | See attached Benefit Cost rate table – Tab 3 |
| **25** | What is the specific percentage of commissions paid to your current Broker/Consultant by the Medical, Dental, Vision, EAP, Life, AD&D, Voluntary Short Term Disability and Voluntary Long Term Disability carriers? | | Medical – 1%<br>Dental – 3%<br>Vision – Standard sliding scale<br>Life/AD&D – 5%<br>LTD - Standard sliding scale |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **26** | What were the annual commissions paid for 2019 and 2020 (to date) to the current Broker/Consultant by carrier for the Medical, Dental, Vision, Life and EAP? | | n/a |
| **27** | If your current Broker/Consultant provided a Broker Compensation Disclosure Report for 2019, please include that report. | | n/a |
| **28** | How does the Court handle enrollment: online or paper with fillable PDF documents?<br>a. We understand the Court recently implemented Workday HRIS for Payroll and to streamline Court processes. Has the Court purchased and does the Court plan to implement Workday's Benefits administration HRIS system?<br>b. Does the Court currently have a benefits web portal or benefits intranet? | | The Court manages the majority of enrollment online through the Court's HR information system Workday. Enrollment for some voluntary benefit programs is still managed with paper enrollment forms.<br>a. Yes, the Court uses Workday to administer Benefits.<br>b. Yes, the Court has a Benefits intranet, as well as access to benefits information through Workday. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **29** | What are the top four employee benefits issues for the Court? Please provide specifics. | | 1. Overall cost - Maintaining reasonable and affordable benefits premium rates for the employer/employees annually<br>2. Providers - The inability to provide a variety of choices in providers for Court employees to choose from<br>3. Educational component – Educating employees on all aspects of their benefit plan offerings, including discounts available, free services and cost saving features.<br>4. Wellness Program – building and sustaining a Wellness Program to improve, mental and physical, health and decrease the cost associated with treating preventative conditions. |
| **30** | How many employees waive the County's health plans? | | 93 employees waived medical enrollment<br>20 employees waived medical for dependents |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **31** | How many employees waive the County's dental plans? | | We are not tracking the number of employees waiving the dental plan. I would estimate it to be less than 10 % of overall staff. |
| **32** | How many employees waive the voluntary vision plan?<br>a. Have employees requested the Court contribute to the Vision plan?<br>b. Is the Court considering contributing for 2021? | | Approximately 50% of staff.<br>a. Not to mind knowledge.<br>b. No. The court provides vision reimbursement to employees within their union agreement; Management employees can utilize their cafeteria funds. |
| **33** | It is noted in Sections 2.1 (G) and (K) sample documents are requested for July 2015 through June 2019. Are these accurate dates or should we provide more recent samples? | | Proposer's are free to submit more recent samples if available. |
| **34** | Please provide your 2021 renewal increases for: Medical, Dental and Vision. | | SHP – 2.87%<br>Kaiser – 4.90%<br>Delta Dental PPO – 5% decrease<br>Deltacare – no change<br>Vision – no change |
| **35** | Were any of your Medical, Dental, Vision or Life/Disabilities sent to market/RFP for the 2021 Plan year? If so, please describe. | | No. |
| **36** | Did you make any contribution changes for the 2021 plan year? If yes, please describe. | | No contribution changes were made for 2021. |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **37** | Did you make any carrier changes for the 2021 plan year for Medical, Dental or Vision? If yes, please describe. | | No. |
| **38** | Did you make any plan design changes to your Medical, Dental and Vision plans for the 2021 plan year? If yes, please describe. | | No. |
| **39** | Did you add or remove any plan options for your 2021 plan year for Medical, Dental or Vision? If yes, please describe. | | No. |
| **40** | Please describe how you are handling Open Enrollment this year? What tools and resources are you utilizing to communicate with employees and their families? | | 1. Flyers, Benefits guide and correspondence sent via email and posted on internal website<br>2. Posting 2021 plan documents on internal website<br>3. Hosting virtual benefit games to increase staff knowledge about benefits<br>4. Virtual webinar with carriers hosted by brokers<br>5. Online Enrollment via Workday desktop and mobile |

| Q # | Questions | RFP Reference (Document & Page-Section-Item) | Answers |
|---|---|---|---|
| **41** | What are the top 3 goals you'd like to achieve in 2021 with your selected Broker/Consultant? | | 1. A review of our benefits plans and providers to ensure the best rates and plan design options for the health and wellness of our court staff<br>2. Exploring new and innovative ways to approach benefits administration and wellness initiatives at our court<br>3. Building/solidifying positive and effective working relationships with the broker team and the court's benefits team |

**Superior Court of California, County of Alameda**
**Plans by Tier Level**
**Attachment to Benefit Broker Proposals**

| Current Plans | Vendor/Carrier | Number of Enrollees | Number of Dependents | Total |
|---|---|---|---|---|
| **Medical** | Kaiser Permanente HMO- Courts | 386 | 392 | 778 |
| | Sutter Health Plus HMO - Courts | 137 | 152 | 289 |
| | Operating Engineers (union plan) –<br>(1) Kaiser<br>(2) Blue Cross | <br>47<br>13 | <br>82<br>17 | <br>129<br>32 |
| **Dental** | Delta Dental PPO (Courts) | 566 | 688 | 1254 |
| | Deltacare USA (DHMO) (Courts) | 24 | 25 | 49 |
| | Delta Dental Operating Engineers (union plan) | 60 | 105 | 165 |
| **Vision** | Vision Service Plan (VSP) (Courts) | 312 | 268 | 580 |
| | Vision Service Plan (VSP) Operating Engineers (union plan) | 58 | 91 | 149 |
| **Long Term Disability (LTD)** | The Hartford Insurance | 94 | | 94 |
| | | | | |
| **Life Insurance -**<br>**Basic Life & AD&D**<br>**Voluntary Life**<br>**Voluntary AD&D**<br>**Dependent Life** | The Standard | <br>666<br>233<br>178 | <br><br><br><br>140 | <br>666<br>233<br>160<br>140 |
| **Flexible Spending Accounts Health & Dependent Care** | Basic Pacific | 176 | | 176 |
| **Employee Assistance Program** | Claremont | 688 | | 688 |
| **Pet Insurance** | Nationwide | | | 25 |
| **Legal Plan & Identify Theft** | ARAG | | | 9 |
| **Cancer Indemnity** | Allstate | | | 7 |

**Estimated numbers of enrollments as of September 2020**

DELTA DENTAL

# Keep Smiling

## Delta Dental PPO℠

### Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.[4]

### Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at **deltadentalins.com**. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

### Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

### Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

### Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[5] You can find this date by logging in to Online Services.

### Newly covered?

Visit **deltadentalins.com/welcome**.

## Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

[4] We recommend verifying before each appointment that your dentist is a PPO dentist.

[5] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

**LEGAL NOTICES:** Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.


HL_PPO #96083E (rev. 5/16)

**Plan Benefit Highlights for:** Superior Court of CA, County of Alameda

**Group No:** 06402 -00001 & 09001

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

| **Eligibility** | Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26 | | | |
|---|---|---|---|---|
| **Deductibles** | $25 per person / $50 per family each calendar year | | | |
| Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics? | Yes | | | |
| **Maximums** | $1,600 per person each calendar year | | | |
| D & P counts toward maximum? | No - **Delta Dental PPO dentists only** | | | |
| **Waiting Period(s)** | Basic Benefits None | Major Benefits None | Prosthodontics None | Orthodontics None |

| **Benefits and Covered Services*** | **Delta Dental PPO dentists**** | **Non-Delta Dental PPO dentists**** |
|---|---|---|
| **Diagnostic & Preventive Services (D & P)** Exams, cleanings and x-rays | 100 % | 100 % |
| **Basic Services** Fillings, simple tooth extractions and sealants | 80 % | 80 % |
| **Endodontics** (root canals) Covered Under Basic Services | 80 % | 80 % |
| **Periodontics** (gum treatment) Covered Under Basic Services | 80 % | 80 % |
| **Oral Surgery** Covered Under Basic Services | 80 % | 80 % |
| **Major Services** Crowns, inlays, onlays and cast restorations | 80 % | 80 % |
| **Prosthodontics** Bridges, dentures and implants | 80 % | 80 % |
| **Orthodontic Benefits** Adults and dependent children | 50 % | 50 % |
| **Orthodontic Maximums** | $1,500 Lifetime | $1,500 Lifetime |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

**Customer Service**
800-765-6003

**Claims Address**
P.O. Box 997330
Sacramento, CA 95899-7330

## deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

**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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No.** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$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 | $15 / visit | Not Covered | None |
| | Specialist visit | $15 / visit | Not Covered | None |
| | Preventive care/ screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services 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**<br><br>**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 | $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. |
| | Non-preferred brand drugs | Same as preferred brand drugs | Not Covered | Same as preferred brand drugs when approved through exception process. |
| | Specialty drugs | $10 / prescription | Not Covered | Up to a 30-day supply retail. Subject to formulary guidelines. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $15 / procedure | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room care | $100 / visit | $100 / visit | None |
| | Emergency medical transportation | $50 / trip | $50 / trip | None |
| | Urgent care | $15 / visit | $15 / visit | Non-Plan providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 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: $15 / individual visit. No Charge for other outpatient services; Substance Abuse: $15 / individual visit. $5 / day for other outpatient services | Not Covered | Mental / Behavioral Health: $7 / group visit; Substance Abuse: $5 / group visit. |
| | Inpatient services | 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: $15 / visit | Not Covered | None |
| | Habilitation services | $15 / visit | Not Covered | None |
| | Skilled nursing care | No Charge | Not Covered | Up to 100 days maximum / benefit period. |
| | Durable medical equipment | No Charge | Not Covered | Requires prior authorization. |
| | Hospice service | No Charge | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

## Excluded Services & Other Covered Services:

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

- Children's glasses
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (plan provider referred)
- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)

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

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information 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 | $15 |
| 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 | $15 |
| 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 | $700 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $50 |
| **The total Joe would pay is** | **$750** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $15 |
| Hospital (facility) copayment | $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 | $200 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$200** |

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

# Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *hhs.gov/ocr/office/file/index.html*.

## Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horasdel día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage) o Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- Completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en Su Guía o en el directorio de centros de atención en nuestro sitio web en **kp.org/espanol**)
- Enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en Su Guía o en el directorio de centros de atención en nuestro sitio web en **kp.org/espanol**)
- Llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- Completando el formulario de queja en nuestro sitio web en **kp.org/espanol**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés)* o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html (en inglés)*.

# 無歧視公告

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天每天 24 小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您還可免費索取翻譯成您的語言的資料，以及符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》*(Evidence of Coverage)*或《保險證明書》*(Certificate of Insurance)*，或咨詢會員服務代表。如果您是 Medicare、MediCal、高風險醫療保險計劃 (Major Risk Medical Insurance Program, MRMIP)、Medi-Cal Access、聯邦僱員健康保險計劃 (Federal Employees Health Benefits Program, FEHBP) 或 CalPERS 會員，採取上述行動尤其重要，因為您可能有不同的爭議解決選項。

您可透過以下方式提出申訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》（地址見《健康服務指南》(Your Guidebook) 或我們網站 **kp.org** 上的服務設施名錄）
- 將書面申訴信郵寄到健康保險計劃服務設施的會員服務處（地址見《健康服務指南》或我們網站 **kp.org** 上的服務設施名錄）
- 致電我們的會員服務聯絡中心，免費電話號碼是 **1-800-757-7585**（TTY 專線請撥 **711**）
- 在我們的網站上填寫申訴表，網址是 **kp.org**

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente 的民權事務協調員。您也可與 Kaiser Permanente 的民權事務協調員直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室提出民權投訴，網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD）。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

# NOTICE OF LANGUAGE ASSISTANCE

**English:** This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

**Arabic:** تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

**Armenian:** Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից:

**Chinese:** 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

**Farsi:** این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است.

**Hindi:** यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है।

**Hmong:** Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv.

**Japanese:** Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、 **1-800-464-4000** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

**Khmer:**នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផងៗ។

**Korean:** 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

**Laotian:** ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຣຸນາໂທຣ **1-800-464-4000** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ.

**Navajo:** Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitɬįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000** áko saad bee áká i’iilyeed yídííkił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindzį́’ ahéé’ílkidgóó dóó tsosts’id jį́ ąą’át’é. Dahodílzingóne’ éí dá’deelkaal.

**Punjabi:** ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ।

**Russian:** Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней.

**Spanish:** La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

**Tagalog:** Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal.

**Thai:** **นี่เป็นข้อมูลสำคัญจาก** Kaiser Permanente **หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรไปยังหมายเลข 1-800-464-4000 เพื่อขอความช่วยเหลือด้านภาษา สามารถโทรติดต่อได้ตลอด** 24 **ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.**

**Vietnamese:** Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ.

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-844-8392. 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/healthreform or call 1-800-844-8392 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 does not have a deductible. |
| **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?** | The medical coinsurance maximum for contract providers is **$1,500**/individual, **$3,000**/family. The out-of-pocket limit for cost sharing for contract providers (includes copays and coinsurance) is **$5,275**/individual, **$10,550**/family. The out-of-pocket limit for in-network outpatient prescription drugs is **$1,875**/individual, **$3,750**/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?** | Medical out-of-pocket limit does not include: premiums, balance-billing charges, penalties for failure to obtain preauthorization, outpatient prescription drug expenses, dental and vision expenses, non-contract provider cost sharing (except for emergency room care for an emergency medical condition) and health care this plan doesn't cover. Prescription drug out-of-pocket limit (in-network) does not include premiums, balance-billing charges, amounts over the generic equivalent cost if you choose a brand drug when a generic is available, medical expenses, dental and vision expenses, out-of-network pharmacy expenses, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com/ca or call 1-800-844-8392 for a list of contract providers in California. For a list of Blue Card contract providers outside of California, see www.bluecares.com or call 1-800-810-2583. For a list of chemical dependency providers, call Assistance & Recovery Program (ARP) at 1-800-562-3277. | You pay the least if you use a contract provider. You pay more if you use an out-of-area provider. You will pay the most if you use a non-contract 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 can see the specialist you choose without a referral. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Contract Provider (You will pay the least) | Out-of-Area Provider (You will pay more) | Non-Contract 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 | $10 copay/visit. | $10 copay/visit plus 10% coinsurance. | $10 copay/visit plus 40% coinsurance | None. |
| | Specialist visit | $10 copay/visit | $10 copay/visit plus 10% coinsurance. | 40% coinsurance | Second surgical opinion not subject to a copay. |
| **If you visit a health care provider's office or clinic** | Preventive care/screening/ Immunization | No charge | Routine physical exam + related diagnostic tests: No charge up to $150/exam. You are responsible for all amounts above $150. Mammogram and immunizations: 10% coinsurance. Well-child care: 10% coinsurance. | Routine physical exam + related diagnostic tests: No charge up to $150/exam. You are responsible for all amounts above $150. Mammogram and immunizations: 40% coinsurance. Well-child care: 40% coinsurance. | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Non-contract provider services limited to physical exam + related diagnostic tests, immunizations, mammography, and well-child care (subject to age and frequency limitations). |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 10% coinsurance | 40% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 10% coinsurance | 40% coinsurance | Preauthorization required from American Imaging Management. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Contract Provider (You will pay the least) | Out-of-Area Provider (You will pay more) | Non-Contract Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com or call 1-855-672-3644. | Generic drugs | Retail (34-day supply): $5 copay/fill Mail Order (90-day supply): $10 copay/fill | You pay 100% up front and submit a claim for reimbursement. The plan will reimburse no more than it would have paid had you used a network retail pharmacy. | | • Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit).<br>• If the drug cost is less than the cost sharing, you pay just the drug cost.<br>• 90-day supply available at retail for three times the otherwise applicable retail copay.<br>• If you choose a brand name drug when a generic is available and medically appropriate, the plan will pay only up to the reasonable cost of the generic equivalent. Any amounts above the cost of the generic equivalent do not count toward your prescription drug out-of-pocket limit.<br>• Some drugs are subject to step therapy or require preauthorization.<br>• No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). |
| | Formulary (Preferred) brand drugs | Retail (34-day supply): 10% coinsurance (maximum $100 copay/fill) Mail Order (90-day supply): 5% coinsurance (maximum $100 copay/fill) | | | |
| | Non-Formulary (Non-preferred) brand drugs | Retail (34-day supply): 25% coinsurance (maximum $200 copay/fill) Mail Order (90-day supply): 15% coinsurance (maximum $200 copay/fill) | | | |
| | Specialty drugs | 20% coinsurance up to the following maximum copays/fill:<br>• Generic: $50<br>• Formulary: $100<br>• Non-Formulary: $200 | Not covered | Not covered | • Chemotherapy drugs may be covered at an out-of-network pharmacy.<br>• Some drugs are subject to step therapy or require preauthorization. Contact Optum for more information. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 10% coinsurance | 20% coinsurance | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Contract Provider (You will pay the least) | Out-of-Area Provider (You will pay more) | Non-Contract Provider (You will pay the most) | |
| | Physician/ surgeon fees | 10% coinsurance | 10% coinsurance | 40% coinsurance | Your cost sharing for services of a non-contract anesthesiologist, assistant surgeon or radiologist will be at the contract level if received in a contract facility and ordered by a contract physician. |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | 10% coinsurance | Professional/physician charges may be billed separately. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | 20% coinsurance | |
| | Urgent care | 20% coinsurance | 20% coinsurance | 20% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 10% coinsurance | 40% coinsurance | Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization required for elective admission. |
| | Physician/ surgeon fees | Physician: $10 copay/visit Surgeon, anesthesiologist: 10% coinsurance | Physician: $10 copay/visit plus 10% coinsurance. Surgeon, anesthesiologist: 10% coinsurance | Physician: $10 copay/visit plus 40% coinsurance. Surgeon, anesthesiologist: 40% coinsurance | Your cost sharing for services of a non-contract anesthesiologist, assistant surgeon or radiologist will be at the contract level if received in a contract facility and ordered by a contract physician. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visit: $10 copay/visit. Other outpatient services: 10% coinsurance | Office visit: $10 copay/ visit plus 10% coinsurance. Other outpatient services: 10% coinsurance | Office visit: $10 copay/visit plus 40% coinsurance Other outpatient services: 40% coinsurance | None. |
| | Inpatient services | Physician: 10% coinsurance Facility and other providers: 10% coinsurance | Physician: 10% coinsurance Facility and other providers: 10% coinsurance | Physician: 40% coinsurance Facility and other providers: 40% coinsurance | Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization from Anthem required for elective mental health admission, from ARP for elective chemical dependency admission. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Contract Provider (You will pay the least) | Out-of-Area Provider (You will pay more) | Non-Contract Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | No charge | $10 copay/visit plus 10% coinsurance. | 40% coinsurance | • Depending on the type of services, a copay or coinsurance may apply.<br>• Maternity care may include tests and services described somewhere else in the SBC (see row titled "If you have a test" for coverage of an ultrasound). |
| | Childbirth/delivery professional services | Physician: $10 copay/visit<br>Surgeon, anesthesiologist: 10% coinsurance | Physician: $10 copay/visit plus 10% coinsurance.<br>Surgeon, anesthesiologist: 10% coinsurance | Physician: $10 copay/visit plus 40% coinsurance.<br>Surgeon, anesthesiologist: 40% coinsurance | Delivery expenses are not covered for dependent children. |
| | Childbirth/ delivery facility services | 10% coinsurance | 10% coinsurance | 40% coinsurance | Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization required for hospital stay longer than 48 hours for vaginal delivery or 96 hours for cesarean section. Delivery expenses are not covered for dependent children. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 10% coinsurance | 10% coinsurance | Limited to 1 visit/day, 60 visits/year. |
| | Rehabilitation services | 10% coinsurance | 10% coinsurance | 40% coinsurance | Medically necessary speech therapy is covered. Preauthorization required for elective inpatient admission. Limited to 40 visits/year for physical therapy and chiropractic care combined. |
| | Habilitation services | 10% coinsurance | 10% coinsurance | 40% coinsurance | Only delay in childhood speech is covered. Limited to 20 visits/year, 40 visits/lifetime. |
| | Skilled nursing care | 10% coinsurance | 10% coinsurance | 10% coinsurance | Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization required for elective admission. Limited to 180 days/year. Admission must begin within 14 days of inpatient hospital stay. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Contract Provider (You will pay the least) | Out-of-Area Provider (You will pay more) | Non-Contract Provider (You will pay the most) | |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 20% coinsurance | Preauthorization recommended for any equipment costing more than $500. Rental charges covered up to reasonable purchase price. |
| | Hospice services | 10% coinsurance | 10% coinsurance | 40% coinsurance | Limited to 1 visit/day, per provider, 60 visits/year. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered | If your employer elects to include the optional vision plan, it will be through a separate VSP policy. |
| | Children's glasses | Not covered | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | If your employer elects to include the optional dental plan, it will be through a separate Delta Dental policy. |

**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
- Dental care (Adult & Child) (may be available through separate dental plan)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult & Child) (may be available through separate vision plan)
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture (limited to 1 visit/week and 12 visits/diagnosis unless preauthorization is obtained)
- Bariatric surgery (only in a Center of Medical Excellence or Blue Distinction Center. Preauthorization required)
- Chiropractic care (up to 40 visits/year combined with physical therapy)
- Hearing aids (limited to $450/ear every 3 years)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Fund Office at 1-800-444-8392. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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 1-800-444-8392.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-444-8392.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-444-8392.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-444-8392.

*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** **$10**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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 | $0 |
| Copayments | $50 |
| Coinsurance | $1,140 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Peg would pay is** | **$1,200** |

## 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** **$10**
- **Hospital (facility) coinsurance** **10%**
- **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 | $0 |
| Copayments | $240 |
| Coinsurance | $540 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | **$810** |

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) coinsurance** **10%**
- **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 | $0 |
| Copayments | $40 |
| Coinsurance | $220 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$260** |

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

**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 sutterhealthplus.org or call 1-855-315-5800. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment (copay), deductible, provider, or other underlined terms see the Glossary of Health Coverage and Medical Terms. You can view the Glossary at sutterhealthplus.org or call 1-855-315-5800 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** individual/ **$0** individual family member/ **$0** family per calendar year. | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes.<br>There is no deductible for covered services. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment (copay) 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 healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$1,000** individual/ **$1,000** individual family member/ **$2,000** family per calendar year. | 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 cost sharing for optional benefits and riders if elected by your employer group. | 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 a list of participating providers, go to sutterhealthplus.org or call 1-855-315-5800. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copay per visit | Not covered | None |
| | Specialist visit | $10 copay per visit | Not covered | Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges. |
| | 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) | Lab: $10 copay per visit<br>X-ray: No charge | Not covered | Prior authorization for some diagnostic services is required. If it is not received, you may be responsible for paying all charges. |
| | Imaging (CT/PET scans, MRIs) | $50 copay per procedure | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage, including the Sutter Health Plus (SHP) Formulary, is available express-scripts.com or call 1-877-787-8661. | Tier 1 | Retail: $5 copay per prescription<br>Mail-Order: $10 copay per prescription | Not covered | Retail: up to a 30-day supply.<br>Mail-Order: up to a 100-day supply.<br>Specialty Pharmacy: up to a 30-day supply.<br><br>FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply.<br><br>Some drugs have process requirements, such as prior authorization, or limitations for coverage, such as a quantity limit. Please refer to the SHP Formulary for details.<br><br>The difference in cost for obtaining a brand drug, when a FDA-approved generic equivalent is available, is not a covered expense and will not accrue towards your out-of-pocket limit unless prior authorized for medical necessity. |
| | Tier 2 | Retail: $20 copay per prescription<br>Mail-Order: $40 copay per prescription | Not covered | |
| | Tier 3 | Retail: $40 copay per prescription<br>Mail-Order: $80 copay per prescription | Not covered | |
| | Tier 4 | Specialty Pharmacy: 10% coinsurance up to $250 per prescription | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
| | Physician/surgeon fee | No charge | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you need immediate medical attention** | Emergency room care | Facility: $50 copay per visit<br>Professional: No charge | | Cost sharing does not apply if admitted for hospitalization for covered services. |
| | Emergency medical transportation | $50 copay per trip | | Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered. |
| | Urgent care | $10 copay per visit | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | Not covered | Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
| | Physician/surgeon fees | No charge | Not covered | |
| **If you need mental health, behavioral health, or substance use disorder (MH/SUD) services**<br>More information about US Behavioral Health Plan, California is available at liveandworkwell.com or call 1-855-202-0984. | Outpatient services | Individual office visit: $10 copay per visit<br>Group office visit: $5 copay per visit<br>Other outpatient services: No charge | Not covered | Prior authorization is required for Other outpatient services and all Inpatient services by US Behavioral Health Plan, California. If it is not obtained when required, you may be liable for the payment of services or supplies. |
| | Inpatient services | Facility and Professional: No charge | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you are pregnant** | Office visits | Prenatal and postnatal care: No charge | Not covered | Prenatal and postnatal care includes all prenatal office visits and the first postnatal office visit. Refer to the primary care visit cost sharing for all subsequent postnatal office visits. |
| | Childbirth/delivery professional services | No charge | Not covered | None |
| | Childbirth/delivery facility services | No charge | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Prior authorization is required. If it is not received, you may be responsible for paying all charges.<br>Quantitative limits exist for the following services:<br>Home health care – 100 visits per calendar year.<br>Skilled nursing care – 100 days per benefit period.<br>Hospice services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time. |
| | Rehabilitation services | No charge | Not covered | |
| | Habilitation services | Not covered | Not covered | |
| | Skilled nursing care | No charge | Not covered | |
| | Durable medical equipment | No charge | Not covered | |
| | Hospice services | No charge | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions and Other Important Information |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Up to $45 max reimbursement | 1 preventive exam per year. Offered through Vision Service Plan (VSP). |
| | 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.)**

- Chiropractic care
- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture services typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. A primary care physician referral and prior authorization are required.
- Bariatric surgery
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

**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: Sutter Health Plus at 1-855-315-5800; The Department of Managed Health Care at 1-888-466-2219 or dmhc.ca.gov; The U.S. Department of Labor, Employee benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 - option 4 - ext. 61565 or cciio.cms.gov. 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 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 for assistance, contact: Sutter Health Plus at 1-855-315-5800 (TTY: 1-855-830-3500) or visit sutterhealthplus.org.

If this coverage is subject to ERISA, you may contact Sutter Health Plus at 1-855-315-5800 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform, and the California Department of Insurance at 1-800-927-HELP (4357) or insurance.ca.gov.

Additionally, a consumer assistance program can help you file your appeal:
Contact Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814
1-888-466-2219 (TTY: 1-877-688-9891) | healthhelp.ca.gov | helpline@dmhc.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:**
Please see Notice of Language Assistance addendum.

*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 (copays) 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 prenatal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) copayment** | **$0** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services *(anesthesia)*
Diagnostic tests (*ultrasounds and blood work)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible | $0 |
| Copayments | $80 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or excluded services | $60 |
| **The total Peg would pay is** | **$140** |

### 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** | **$10** |
| **Hospital (facility) copayment** | **$0** |
| **Other coinsurance** | **10%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(including glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible | $0 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or excluded services | $60 |
| **The total Joe would pay is** | **$1,060** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$10** |
| **Hospital (facility) copayment** | **$0** |
| **Other coinsurance** | **10%** |

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

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible | $0 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or excluded services | $0 |
| **The total Mia would pay is** | **$100** |

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

Sutter Health Plus
Your Health Plan

# Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صَتر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلُغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صَتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرئي [TTY]1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա։ Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն։ Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով։ Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով։ (Armenian)

**សារៈសំខាន់ៈ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ** Sutter Health Plus **អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក** Sutter Health Plus **តាមលេខ** 1-855-315-5800 (TTY 1-855-830-3500)**។** (Cambodian)

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفا با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

**महत्वपूर्ण:** क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) **पर सट्टर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें।** (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができます？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

**ໝາຍເຫດ**: **ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່**? **ຖ້າ**ທ່ານອ່ານບໍ່ໄດ້, **ທາງ** Sutter Health Plus **ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ**. **ນອກຈາກນັ້ນ**, **ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ**. **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ**, **ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ** Sutter Health Plus **ທີ່ໝາຍເລກໂທລະສັບ** 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

**สำคัญ**: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)

# A LOOK AT YOUR VSP VISION COVERAGE

## SEE HEALTHY AND LIVE HAPPY WITH HELP FROM SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA AND VSP.

VSP® Vision care for life

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

### VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

### PROVIDER CHOICES YOU WANT.

PREMIER PROGRAM

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

**Prefer to shop online?** Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

### QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

**Enjoy more savings and offers.**

Get access to more than $3,000 in savings with **VSP Exclusive Member Extras**, like rebates for popular contact lens brands, savings on LASIK, and more.

### GET YOUR PERFECT PAIR

**EXTRA $20** TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

+ UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

## Enroll today.

Contact us: **800.877.7195** or **vsp.com**

## YOUR VSP VISION BENEFITS SUMMARY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA and VSP provide you with an affordable vision plan.

**PROVIDER NETWORK:**
VSP Choice

**EFFECTIVE DATE:**
01/01/2020

| Benefit | Description | Copay | Frequency |
|---|---|---|---|
| **Your Coverage with a VSP Provider** | | | |
| **WellVision Exam** | • Focuses on your eyes and overall wellness | $10 | Every calendar year |
| **PRESCRIPTION GLASSES** | | $25 | See frame and lenses |
| **Frame** | • $150 allowance for a wide selection of frames<br>• $170 allowance for featured frame brands<br>• 20% savings on the amount over your allowance | Included in Prescription Glasses | Every calendar year |
| **Lenses** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every calendar year |
| **Lens Enhancements** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 20-25% on other lens enhancements | $0<br>$95 - $105<br>$150 - $175 | Every calendar year |
| **Contacts (instead of glasses)** | • $130 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation) | Up to $60 | Every calendar year |
| **PRIMARY EYECARE** | • As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details. | $20 | As needed |
| **EXTRA SAVINGS** | **Glasses and Sunglasses**<br>• Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.<br>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. | | |
| | **Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam | | |
| | **Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities | | |
| **Your Monthly Contribution** | $11.02 Member only $17.12 Member + 1 $27.15 Member + family | | |

### YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

| | | |
|---|---|---|
| Exam ..... up to $45 | Lined Bifocal Lenses ..... up to $50 | Progressive Lenses ..... up to $50 |
| Frame ..... up to $70 | Lined Trifocal Lenses ..... up to $65 | Contacts ..... up to $105 |
| Single Vision Lenses ..... up to $30 | | |

Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit vsp.com for details. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.