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, go online at www.cigna.com/sp. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	For in-network providers: $1,000/individual or $2,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	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, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 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 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, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	None
	Specialist visit	$20 copay/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge/visit No charge/visit No charge/screening No charge/screening No charge/immunizations No charge/immunizations	Not covered	Coverage birth through age 16 Coverage age 17 and older Coverage birth through age 16 Coverage age 17 and older Coverage birth through age 16 Coverage age 17 and older 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail 90 days); $20 copay/prescription (home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $60 copay/prescription (retail 90 days); $60 copay/prescription (home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail 30 days), $100 copay/prescription (retail 90 days); $100 copay/prescription (home delivery 90 days)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share.
	Urgent care	$25 copay/visit	$25 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit No charge/all other services	Not covered	None
	Inpatient services	$100 copay/admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. 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	
	Childbirth/delivery facility services	$100 copay/admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	16 hour maximum per day
	Rehabilitation services	$20 copay/PCP visit $20 copay/ Specialist visit $15 copay/visit for Chiropractic care	Not covered	Coverage is limited to annual max of: 30 days for Chiropractic care services
	Habilitation services	$20 copay/PCP visit $20 copay/ Specialist visit	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care (30 days)
- Infertility treatment

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: California Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.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 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 on how 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: Cigna Customer service at 1-800-Cigna24. You may also contact the California Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center at (888) 466-2219.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$120

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	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$720

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$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.

Plan Name: HMO Choice Plan **Ben Ver:** 25 **Plan ID:** 15659665 HMO GSA 9/23/12

PAGE INTENTIONALLY BLANK

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. 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 https://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 http://www.hhs.gov/ocr/office/file/index.html.

896375b 05/21

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375a 05/17

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, go online at www.cigna.com/sp. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	For in-network providers: $750/individual or $1,500/family Combined medical/behavioral and pharmacy out-of-pocket limit	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, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 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 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, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	Not covered	None
	Specialist visit	$10 copay/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge/visit No charge/visit No charge/screening No charge/screening No charge/immunizations No charge/immunizations	Not covered	Coverage birth through age 16 Coverage age 17 and older Coverage birth through age 16 Coverage age 17 and older Coverage birth through age 16 Coverage age 17 and older 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail 90 days); $20 copay/prescription (home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $60 copay/prescription (retail 90 days); $60 copay/prescription (home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail 30 days), $100 copay/prescription (retail 90 days); $100 copay/prescription (home delivery 90 days)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share.
	Urgent care	$25 copay/visit	$25 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No charge/all other services	Not covered	None
	Inpatient services	$100 copay/admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. 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	
	Childbirth/delivery facility services	$100 copay/admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	16 hour maximum per day
	Rehabilitation services	$5 copay/PCP visit $10 copay/ Specialist visit $10 copay/visit for Chiropractic care	Not covered	None
	Habilitation services	$5 copay/PCP visit $10 copay/ Specialist visit	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

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: California Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.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 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 on how 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: Cigna Customer service at 1-800-Cigna24. You may also contact the California Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center at (888) 466-2219.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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	**0%**
Other coinsurance	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$120

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	**0%**
Other coinsurance	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$520

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	**0%**
Other coinsurance	**0%**

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	**$2,800**

In this example, Mia would pay:

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

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

Plan Name: HMO Select Plan **Ben Ver:** 25 **Plan ID:** 15659666 HMO GSA 9/23/12

PAGE INTENTIONALLY BLANK

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. 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 https://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 http://www.hhs.gov/ocr/office/file/index.html.

896375b 05/21

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375a 05/17

KAISER PERMANENTE® : TRADITIONAL PLAN

Coverage for: Individual/Family | Plan Type: HMO

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 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, 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	$20 / visit	Not Covered	None
	Specialist visit	$20 / 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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	$30 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs (Tier 2)	Same as preferred brand drugs	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	$30 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

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	$50 / visit	$50 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$20 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $20 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: $10 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$100 / admission	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	Professional services are included in the Facility services.
	Childbirth/delivery facility services	$100 / admission	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: $100 / admission; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / 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	Frames: Amount in excess of $100 allowance; Lenses: No charge	Not Covered	Frame allowance limited to once every 24 months. Lenses limited to CR-39 clear plastic or polycarbonate (single vision, flat top multifocal, or lenticular).
	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.)

- 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
- Chiropractic care (30 visit limit / year)
- 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 on how 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.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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** **$20**
- **Hospital (facility) copayment** **$100**
- **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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$150**

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** **$20**
- **Hospital (facility) copayment** **$100**
- **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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$100**
- **Other (x-ray) copayment** **$0**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$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

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call our Member Service Contact Center at **1 800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at 916-440-7370 (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- Online: Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  http:www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
    - ♦ intérpretes calificados de lenguaje de señas,
    - ♦ información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
    - ♦ intérpretes calificados,
    - ♦ información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-464-4000** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al **711**.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su *Evidencia de Cobertura (Evidence of Coverage) o Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** llame a Servicio a los Miembros al **1 800-464-4000** (TTY **711**), las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** llámenos al **1 800-464-4000** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- **En línea:** utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Los formularios de queja están disponibles en: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).**

- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov.

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al **1-800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Los formularios de quejas están disponibles en
  http://www.hhs.gov/ocr/office/file/index.html (en inglés).

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente 遵守州政府與聯邦政府的民權法。

Kaiser Permanente 不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente 提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
    - ♦ 合格手語翻譯員
    - ♦ 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
    - ♦ 合格口譯員
    - ♦ 其他語言的書面資訊

如果您需要上述服務，請打電話 1-800-464-4000 (TTY 711) 給會員服務聯絡中心，每週 7 天，每天 24 小時（節假日除外）。如果您有聽力或語言困難，請打電話 711。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向 Kaiser Permanente 投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向 Kaiser Permanente 提出歧視投訴。請參閱您的《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明》*(Certificate of Insurance)* 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話：** 打電話 1 800-464-4000 (TTY 711) 聯絡會員服務部，每週 7 天，每天 24 小時（節假日除外）
- **郵寄：** 打電話 1 800-464-4000 (TTY 711) 與我們聯絡，要求將投訴表寄給您
- **親自提出：** 在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在 kp.org/facilities 網站的保健業者名錄上查詢地址）
- **線上：** 使用 kp.org 網站上的線上表格

您也可直接與 Kaiser Permanente 民權事務協調員聯絡，地址如下：

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

如何向加州保健服務部民權辦公室投訴（僅限 *Medi-Cal* 受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話：**打電話 916-440-7370 (TTY 711) 聯絡保健服務部 (DHCS) 民權辦公室
- **郵寄：**填寫投訴表或寄信至：

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  您可在網站上 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 取得投訴表
- **線上：**發送電子郵件至 CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話：**打電話 1-800-368-1019（TTY 711 或 1-800-537-7697）
- **郵寄：**填寫投訴表或寄信至：

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  您可在網站上取得投訴表：
  http:www.hhs.gov/ocr/office/file/index.html 取得投訴表
- **郵寄：**訪問民權辦公室投訴入口網站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.
Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
    - ♦ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
    - ♦ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
    - ♦ Thông dịch viên đủ trình độ
    - ♦ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi **711**.

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Vui lòng tham khảo Chứng Từ Bảo Hiểm (Evidence of Coverage) hay Chứng Nhận Bảo Hiểm (Certificate of Insurance) của quý vị để biết thêm chi tiết. Quý vị cũng có thể nói chuyện với nhân viên ban Dịch Vụ Hội Viên về những lựa chọn áp dụng cho quý vị. Vui lòng gọi đến ban Dịch Vụ Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Gọi đến ban Dịch Vụ Hội Viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- **Qua thư tín:** Gọi chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu gửi mẫu đơn cho quý vị
- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California *(Dành Riêng Cho Người Thụ Hưởng Medi-Cal)*

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Mẫu đơn than phiền hiện có tại: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**

- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Mẫu đơn than phiền hiện có tại
  http:www.hhs.gov/ocr/office/file/index.html

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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 TTY 711** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays. We can also help you with auxiliary aids and alternative formats.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.
الرقم **1-800-464-4000 (TTY: 711)** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء
يمكننا أيضاً تزويدك بمساعدات إضافية وتنسيقات بديلة.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000 (TTY 711)**հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից: Մենք նաև կարող ենք օգնել Ձեզ օժանդակ օգնության և այլընտրանքային ձևաչափերի հարցում:

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** (TTY **專線** 711) 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）。我們還可以幫助您獲取輔助設備和其它格式。

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 (TTY 711)**تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است. ما همچنین می توانیم برای شما کمکهای جانبی و به صورتهای دیگر را فراهم کنیم.

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 (TTY 711)** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है। हम सहायक साधनों और वैकल्पिक प्रारूपों को प्राप्त करने में भी आपकी मदद कर सकते हैं।

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 (TTY 711)** 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. Peb kuj muab tau lwm yam kev pab rau koj thiab ua lwm yam ntaub ntawv.

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** (TTY **回線** 711) 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。補助器具・サービスや別のフォーマットについてもご相談いただけます。

Khmer:នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** (**TTY** 711) នងស្នើសុំជំនួយខាងភាសា។ ជំនួយគមាន 24 មោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រមទាងថ្ងៃបុណ្យផង។
យើងកអាចជួយអ្នកជាមួយនឹងឧបករណជំនួយទនាកទនងសម្រាបអ្នកពការនឹងជាទម្រងជនួសផ្សេង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** (TTY 711) 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외). 또한 보조기구 및 대체 형식의 자료를 지원해 드릴 수 있습니다.

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະລຸນາໂທຣ **1-800-464-4000 (TTY 711)** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ. ພວກເຮົາຍັງສາມາດຊ່ວຍທ່ານໃນດ້ານອຸປະກອນຊ່ວຍເສີມ ແລະ ຮູບແບບທາງເລືອກອື່ນໄດ.

Mien: Naaiv se benx jienv sic dauh waac-fienx yiem naaiv Kaiser Permanente bun daaih. Beiv taux meih qiemx longc mienh tengx doqc naaiv deix waac-fienx liouh porv bun bieqc hnyouv nor, daaix luic douc waac daaih lorx **1-800-464-4000 (TTY 711)** aengx caux tov heuc tengx nzie faan waac bun muangx. Mbenc nzoih liouh tengx yiem yietc hnoi benx 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi, simv cuotv hnoi-gec oc. Yie mbuo corc haih mbenc wuotc ginc jaa-dorngx tengx nzie goux aengx caux liouh bun ginv longc sou-guv daan puix horpc meih.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitįįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000 (TTY 711)** áko saad bee áká i’iilyeed yídííkił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindzį́į’ ahéé’ílkidgóó dóó tsosts’id jį́ ąą’át’é. Dahodílzingóne’ éí dá’deelkaal. Áádóó hane’ bee bik’i’ di’díítíiłígíí dóó t’áá łahgo át’éego hane’ nich’į ádoolníił.

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 (TTY 711)** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ। ਅਸੀਂ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਵੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000 (линия TTY 711)** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616 (TTY 711)** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos. También podemos ayudarle con recursos para discapacidades y formatos alternativos.

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 (TTY 711)** 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. Matutulungan din namin kayo sa mga pantulong na gamit o serbisyo at mga alternatibong format.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ โปรด โทร **1-800-464-4000** (โหมด **TTY 711**) และขอความช่วยเหลือด้านภาษา เราพร้อมให้ความช่วยเหลือตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ ยกเว้นวันหยุดราชการ เรายังสามารถจัดหาอุปกรณ์และวัสดุช่วยเหลือในรูปแบบอื่นได้อีกด้วย

Ukranian:У цьому повідомленні міститься важлива інформація від Kaiser Permanente. Якщо надана інформація не зрозуміла й вам потрібна допомога, зателефонуйте за номером **1-800-464-4000 (TTY 711)** і попросіть надати вам послугу перекладача. Наші співробітники надають допомогу цілодобово, 7 днів на тиждень, за винятком святкових днів. Також ми можемо допомогти вам, надавши допоміжні засоби й матеріали в альтернативних форматах.

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 (TTY 711)** 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. Chúng tôi cũng có thể giúp quý vị với các phương tiện trợ giúp bổ trợ và hình thức thay thế.

blue of california

Coverage Period: 1/1/2023 – 12/31/2023

County of Orange Sharewell Choice **Coverage for:** Individual + Family | **Plan Type:** PPO

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 blueshieldca.com/oc or call **1-888-235-1767**. 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 healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers and non-participating providers **$5,000** per family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. All **copayment** and **coinsurance** costs shown in this chart apply after your **deductible** has been met, if a **deductible** applies.
Are there services covered before you meet your deductible?	Yes. Preventive care listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. 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 separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,000** per family for participating providers; **$12,000** per family for non-participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, balance-billing charges, and penalties for failure to obtain pre-admission review for non- emergency hospitalization and the cost differential between the brand and generic drug if you choose a brand drug when a generic equivalent is available. See Prescription Dug section for limitations, exceptions, and other important information.	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 blueshieldca.com/oc or call **1-888-235-1767** 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 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
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating 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	10% coinsurance	30% coinsurance	----------None----------
If you visit a health care provider's office or clinic	Specialist visit	10% coinsurance	30% coinsurance	
If you visit a health care provider's office or clinic	Preventive care/screening /immunization	No Charge	No Charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	----------None----------
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required for non-emergency Imaging (CT/PET scans, MRIs) within California. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Preventive drugs (in accordance with Health Care Reform)	0% coinsurance	Not Covered	Important Considerations: If member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the full cost differential between generic and brand cost, unless the prescriber specifically requests the brand name (dispense as written, do not substitute) The cost differential does not count towards the out-of-pocket limit for prescription drugs. All Specialty Drugs must be fulfilled by OptumRx Specialty Pharmacy in order to be covered. Manufacturer specialty coupon cards do not count towards the annual deductible or out-of-pocket maximum. Drug Exclusions: The drug formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available. Preauthorization is required for select drugs. Medication not covered by the plan including those filled through Optum's enhanced savings program will not count towards the annual deductible or out-of-pocket maximum.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: **Current members** www.optumrx.com **Prospective members** https://www.optumrx.com/oe_countyoforange/landing	Tier 1: Mostly generic drugs Tier 2: Mostly brand preferred drugs Tier 3: Mostly brand non-preferred drugs	20% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription specialty drug coverage is available at specialty.optumrx.com	Specialty drugs	20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Non-Participating Ambulatory Surgery Center: Up to a maximum of $1,500 per day.
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	----------None----------
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-network: Covered person is responsible for all charges above the current URC amount for Ground Ambulance but only responsible for in-network charges for air ambulance services.
If you need immediate medical attention	Urgent care	10% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	----------None----------
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
If you are pregnant	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating 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	10% coinsurance	30% coinsurance	Preauthorization is required for non-participating providers. Failure to obtain preauthorization may result in non-payment of benefits. When home health care is authorized as an alternative to continued hospitalization in a Network Hospital, the home health care services will be reimbursed at 90%
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	30% coinsurance	----------None----------
If you need help recovering or have other special health needs	Habilitation services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Skilled nursing care	10% coinsurance	30% coinsurance	Combined maximum of up to 100 days per calendar year; semi-private accommodations. Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need help recovering or have other special health needs	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required for equipment in excess of $5,000. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need help recovering or have other special health needs	Hospice services	Inpatient Respite Care 10% coinsurance	Inpatient Respite Care 30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. When Hospice residence immediately follows Inpatient services in a Network Hospital, the Hospice services will be reimbursed at 90%
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Covered under Preventive Services
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	----------None----------
If your child needs dental or eye care	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 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 assistance, contact: Blue Shield Customer Service at 1-855-836-9705 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): **Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih** 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): **日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。**

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi(ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਿਹਰਬਾਨੀ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាសម្រាប់ជនសញ្ជាតិគ្មានថ្លៃ សូមទាក់ទងមកលេខ1-866-346-7198.

Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

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 participating pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **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	$5,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,860**

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,960**

Mia's Simple Fracture
(participating emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

blue of california

Coverage Period: 1/1/2023 – 12/31/2023

County of Orange Wellwise Choice

Coverage for: Individual + Family | **Plan Type:** PPO

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 blueshieldca.com/oc or call **1-888-235-1767**. 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 healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers **$500** individual/ **$1,000** family and non-participating providers **$750** individual/ **$1,500** family. Doesn't apply to preventive care.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. 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 separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: participating providers **$2,500** individual/ **$5,000** family; non-participating **$5,000** individual / **$10,000** family; Prescription Drug: **$4,100** individual/ **$8,200** 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Medical: Coinsurance for certain services, premiums, balance-billing charges, and health care this plan doesn't cover. Prescription Drug: See Prescription Dug section for limitations, exceptions, and other important information.	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 blueshieldca.com/oc or call **1-888-235-1767** 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 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
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating 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	10% coinsurance	30% coinsurance	----------None----------
If you visit a health care provider's office or clinic	Specialist visit	10% coinsurance	30% coinsurance	
If you visit a health care provider's office or clinic	Preventive care/screening /immunization	No Charge	No Charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	----------None----------
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required for non-emergency Imaging (CT/PET scans, MRIs) within California. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Preventive drugs (in accordance with Health Care Reform)	0% coinsurance	Not Covered	Preauthorization is required for select drugs. The formulary may exclude certain drugs. However, every therapeutic class (condition) will have a clinically effective covered drug available. **Not included in the prescription drug out-of-pocket limit:** Drugs not covered by the plan including those filled through Optum's enhanced savings program; and if member chooses brand drug when a generic equivalent is available, member will pay 20% of generic cost plus the cost differential between generic and brand drug. The cost differential does not count towards the prescription drug out-of-pocket limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: **Current members** www.optumrx.com **Prospective members** https://www.optumrx.com/oe_countyoforange/landing	Tier 1: Mostly generic drugs	20% coinsurance	Not Covered	
	Tier 2: Mostly brand preferred drugs	25% coinsurance	Not Covered	
	Tier 3: Mostly brand non-preferred drugs	30% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about prescription specialty drug coverage is available at specialty.optumrx.com	Specialty drugs	Percentage indicated up to a maximum of $150 per 30-day supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Non-Participating Ambulatory Surgery Center: Up to a maximum of $1,500 per day.
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	----------None----------
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-network: Covered person is responsible for all charges above the current URC amount for Ground Ambulance but only responsible for in-network charges for Air Ambulance services.
If you need immediate medical attention	Urgent care	10% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	30% coinsurance	Pre-admission review required. Penalty: Non-Participating only - allowed amount is increased to 50% coinsurance for which the covered person is liable.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	----------None----------
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
If you are pregnant	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating 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	10% coinsurance	30% coinsurance	Preauthorization is required for non-participating providers. Failure to obtain preauthorization may result in non-payment of benefits. When home health care is authorized as an alternative to continued hospitalization in a Network Hospital, the home health care services will be reimbursed at 90%.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	30% coinsurance	----------None----------
If you need help recovering or have other special health needs	Habilitation services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Skilled nursing care	10% coinsurance	30% coinsurance	Combined maximum of up to 100 days per calendar year; semi-private accommodations. Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need help recovering or have other special health needs	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required for equipment in excess of $5,000. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Hospice services	Inpatient Respite Care 10% coinsurance	Inpatient Respite Care 30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. When Hospice residence immediately follows Inpatient services in a Network Hospital, the Hospice services will be reimbursed at 90%.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Covered under Preventive Services
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	----------None----------
If your child needs dental or eye care	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 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 assistance, contact: Blue Shield Customer Service at 1-855-836-9705 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): **Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih** 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): **日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。**

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi(ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਿਹਰਬਾਨੀ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាសម្រាប់ជនសញ្ជាតិគ្មានថ្លៃ សូមទាក់ទងមកលេខ1-866-346-7198.

Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

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 participating pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist coinsurance	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	$5,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,860**

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,960**

Mia's Simple Fracture
(participating emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Waiving Health Coverage

What you need to know

Each year, the County reviews its benefit options in response to a changing market as well as employee needs. As you make your benefit decisions — whether you're a new employee, enrolling during Open Enrollment or making changes in response to a Qualified Life Event (QLE) — it's important to understand how the waived coverage option works.

You'll find information on the other County Health Plan options in the **What to Know** guide on **My OC Benefits™**.

Is Waiving Coverage Right for You?

There are many things to know and consider before making a decision to waive coverage.

Waiving coverage may be right for you if you can access coverage through another entity at a lower cost, or if it includes a different network or provides a benefit that meets a specific need. These plans may include your spouse's/ domestic partner's employer plan or a plan available due to your previous military service.

Waiving Coverage vs. the Sharewell Choice PPO

With Sharewell Choice, the County gives you a payroll credit to be enrolled in this plan, but it's important you understand how coordinating your benefits with other coverage will work.

- If you choose the Sharewell Choice PPO, it would be your primary provider. You would still need to meet the annual deductible before the Plan will begin reimbursing for eligible expenses, and you would need to coordinate benefits with your other health plan.
- If you choose to waive County health coverage, your other plan will be your primary provider. That means no need to coordinate benefits, and you will only have to meet that plan's deductible, if applicable. Of course, you would miss out on the Sharewell payroll credit, but that might be worth it to you.

Things to Think About

If you choose to waive coverage, you will elect "No Coverage" when you enroll.

- You and any currently covered dependents will not have County medical coverage during the plan year. You cannot cover dependents without covering yourself.
- You must attest that you will have other qualifying health coverage as required by the Affordable Care Act (ACA).
- If you experience a QLE, you may be eligible to re-enroll in health coverage, although not every QLE allows you to change coverage. To learn more, model common events in the "**Life Changes**" section of **My OC Benefits™**.

Thinking About Retiring?

If you elect “No Coverage” and then retire during the year, you are still eligible to enroll in a Retiree Medical Plan and will be provided an opportunity to enroll once you initiate your retirement with the Orange County Employees Retirement System.

For more information on initiating your retirement, you’ll want to review the **Intent to Retire** as well as the **Attaining Medicare** summaries.

When Things Change

Typically, you can only make or change benefit elections when you first become eligible for coverage and during Open Enrollment. However, you can make changes during the plan year if you:

- Experience a Qualified Life Event (QLE).
- Experience an eligible change in employment status (e.g., full-time to part-time).
- Begin or end a leave of absence.

Some QLEs do not permit you to change health plans; however, you may be eligible to change your Reimbursement Account elections and other benefits (if applicable). See the “**Life Changes**” section of **My OC Benefits**™ for details and deadlines.

And if You’re on Leave…

The rules for waiving coverage depend on the type of leave you take:

- If you start an unpaid leave, including an unpaid medical leave, you may remain in your current plan, select another plan or choose the “No Coverage” option. You are not required to have other coverage elsewhere.
- If you start a paid leave, you cannot make any changes to your coverage unless you experience a QLE while on leave.
- When you return to work, you may choose a different plan or remain in your current plan, no matter which plan you were in while on your leave. You can also choose to waive coverage, as long as you have coverage elsewhere. If you choose to waive or continue to waive coverage, you will need to attest that you will have other qualifying health coverage as required by the Affordable Care Act (ACA). You will also be required to complete and return the Attestation of Active Employee Waived Health and Proof of Other Coverage form.

Ready to Enroll?

Go to **My OC Benefits™** directly from **IntraOC** or at **mybenefits.ocgov.com**. If it's your first time on the site:

- Select "New User?" on the login page.
- Enter the last four digits of your Social Security Number and your date of birth.
- Follow the prompts to create your user ID and password.

You will see a notification directing you to enroll in your benefits. To enroll, select "View/Change" to see your options.

Are You Waiving Coverage?

If you've decided to waive coverage, select the "No Coverage" option. If you are not on a leave, you'll be prompted to attest that you have coverage elsewhere. After you have elected to waive coverage, a notice will be sent to you accompanied with the Attestation of Active Employee Waived Health and Proof of Other Coverage form. You are required to complete and return the included form by the indicated deadline. If you are currently in "No Coverage" and wish to remain in this option, you will also be sent the notice and will need to complete and return the Attestation of Active Employee Waived Health and Proof of Other Coverage form.

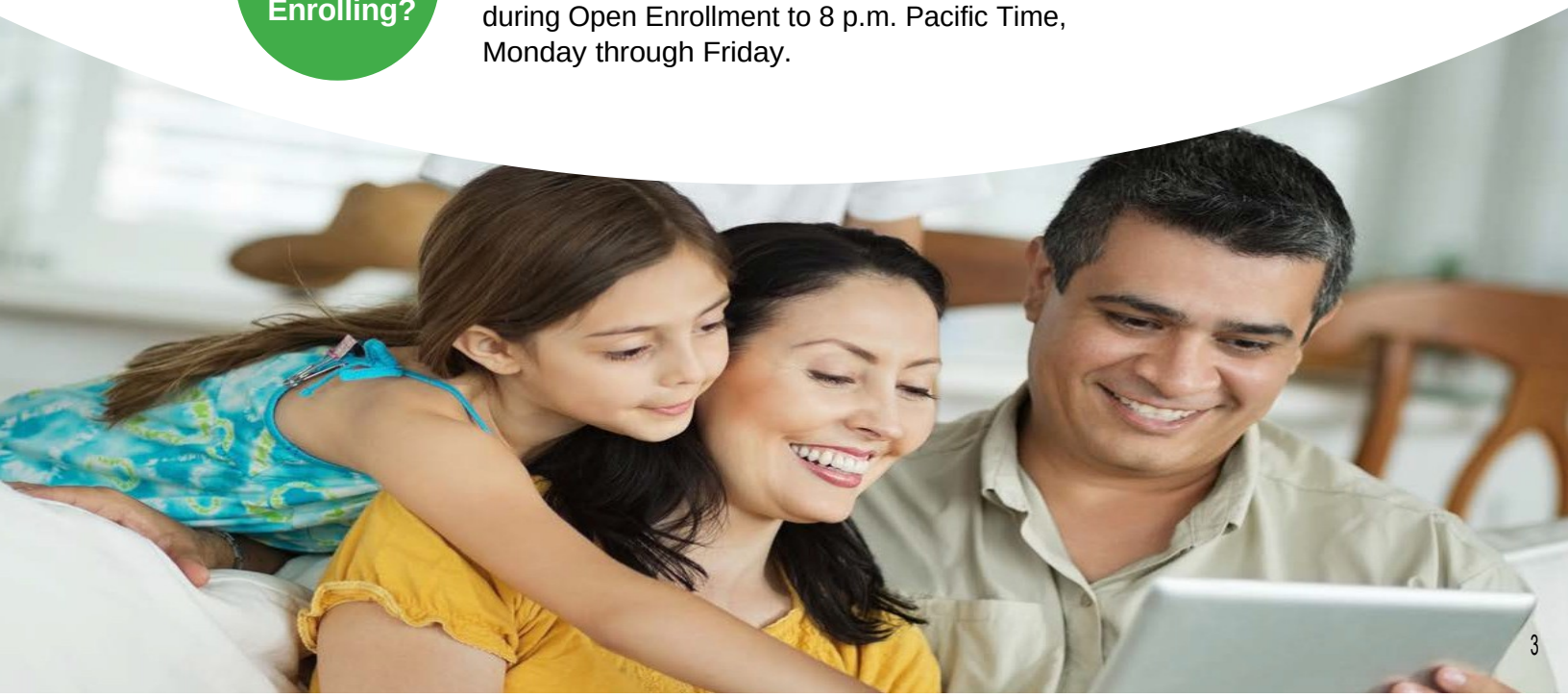
Open Enrollment - Enrolling or Remaining in Waived Coverage

If you are electing "No Coverage" option for the first time during Open Enrollment you will need to attest you have coverage elsewhere and you must provide that proof by the deadline noted on the solicitation sent you after the close of Open Enrollment. If you are currently in "No Coverage" and wish to remain in this option, you will only be required to submit proof of coverage elsewhere as stated above.

If the completed Attestation of Active Employee Waived Health and Proof of Other Coverage form is not received by the deadline, Full time employees will be enrolled in Wellwise Choice PPO employee only coverage, Part time employees will be enrolled in Sharewell Choice PPO employee only coverage.

Questions or Help Enrolling?

Call the **Benefits Service Center** at **1-833-476-2347** between 8 a.m. and 6 p.m. Pacific Time, Monday through Friday. Hours are extended during Open Enrollment to 8 p.m. Pacific Time, Monday through Friday.



Benefits Service Center
PO Box 661162
Dallas, TX 75266-1162

My OC Benefits™
Website: mybenefits.ocgov.com
Phone: 1-833-476-2347
Fax: 1-224-607-3465

Health Benefits For Extra Help Employees

The Affordable Care Act (ACA) requires the County to provide certain Extra Help employees with medical coverage that meets coverage and affordability standards set in the Act. This flier describes who is eligible, the health plan available, and what you need to do to enroll. Your ongoing eligibility for continued coverage under the plan may cease according to changes in your status or hours worked in accordance with the provisions of the ACA. For additional information, please call the Benefits Service Center at 1-833-476-2347.

Am I Eligible for Health Coverage?

Employees Scheduled to Work On An Ongoing Basis 60 Hours Per Pay Period

Only Extra Help employees who are scheduled to work on an ongoing basis of 60 hours or more per pay period are eligible to enroll in the plan as a new employee. You may enroll yourself and any eligible dependents, including your spouse/ domestic partner and dependent children under age 26.

Employees Who Are Seasonal or Have Variable Hour Schedules

Extra Help employees who are considered "seasonal" meaning working for a limited period of time or those who are on a variable hour work schedule during the year are **not** eligible to enroll at this time. If it is later determined that you should be offered coverage, based on the hours you worked over a year's time, the Benefits Service Center will mail you an enrollment solicitation. For questions regarding your Extra Help classification, please speak to your Agency's Human Resource Services representative.

Why Is Coverage Being Offered?

The federal Affordable Care Act (ACA) requires the County to offer minimum essential health coverage to employees who work an average of 30 or more hours a week and are not otherwise eligible for County benefits.

What Health Plan Is Available?

The County Sharewell Choice PPO health plan meets the minimum essential coverage and minimum value standards set by the ACA. A few highlights of the plan:

- Annual $5,000 family deductible
- Preventive care – no charge for services listed in the Plan Document; services are not subject to deductible
- After deductible is met, participant pays 10% coinsurance for services received from Blue Shield of California network providers or 30% for services obtained from non-network providers

Review the Summary of Benefits and Coverage (SBC) for details. You can find the SBC on the My OC Benefits™ at mybenefits.ocgov.com on the Plan Documents page.

How Do I Enroll?

If eligible, the Benefits Service Center will mail you an enrollment solicitation. You will have 30 days from the date on the enrollment solicitation to make your election. You can enroll through My OC Benefits™ or calling the Benefits Service Center and have a representative enroll you. **You MUST elect to enroll in the Sharewell Choice plan within 30 days or you will have no coverage.** Your coverage will go into effect no later than 91 days after your hire date.