trust fund office
local union 831
employer health fund
P.O. Box 3118, Covina, California 91722-9118
Toll Free (877) 572-7005 • Phone (626) 279-3080 • Fax (626) 279-3055
www.localunion831trustfunds.com

Date: December 1, 2025

To: All Participants in the Local 831 Employer Health

From: Local 831 Employer Health Fund

The Board of Trustees adopted a twelve (12) month rolling enrollment, instead of the prior single enrollment date, effective April 1, 2017.

Under the twelve (12) month rolling enrollment, once you choose your Medical Plan, you may change your Medical Plan once during every twelve (12) month period from the date of your last change, provided you have participated in the same Medical Plan for at least twelve (12) months. For example, if you join the Kaiser plan in November 2025, after November 2026 you can change your Medical Plan once between November 2026 and November 2027. If you then change your Medical Plan in January 2027, you would have to wait until January 2028 to make another change.

An exception to this twelve (12) month rule will be made (and you will be able to change plans more than once during the 12-month period) if you move out of the service area of the Medical Plan that you previously chose.

Your changes will not become effective until the first of the month following your election.

When a member first establishes eligibility, the member will be enrolled in the default Medical Plan, which is the Indemnity Plan Level 4. If the eligible member does not want to remain in the Indemnity Plan Level 4, **an enrollment form must be submitted to the Trust Fund Office within 90 days** after establishing eligibility. Once the individual selects the desired Medical Plan, they are bound to stay with that Medical Plan for the next twelve (12*)* months. Members are allowed to increase (move up) their Plan Level of coverage one time during the twelve (12) month period after their Plan Level selection. Members have the option of lowering (move down) the Plan Level during the year as many times as wanted or needed during the year. An Enrollment Form must be submitted to the Trust Fund Office selecting the new Plan Level before the start of the new eligibility month. **The Plan Level change will not be done automatically**. For example, if the member does not have sufficient credits to remain eligible at the Plan Level selected, the member will lose coverage and not simply be dropped to a lower level. A request for a Plan Level change will not be granted if requested after coverage is terminated.

If you are already enrolled in the Fund and you do not want to make any changes to your current coverage, and if the information on your Health Enrollment Form currently on file with the Trust Fund Office is accurate, you do not need to submit an Enrollment / Change Form.

If you want to enroll in the Fund or make any changes (such as switching between the Indemnity Plan and the Kaiser Plan or adding / removing dependents), and you have been enrolled in your current Plan for at least twelve (12) consecutive months, you need to submit an Enrollment / Change Form to the Trust Fund Office. You can contact the Trust Fund Office at (626) 279-3080 or (877) 572-7005 and request an enrollment form to be mailed to you or visit our website at www.localunion831trustfunds.com.

Participant Benefit Lookup Portal
The Participant Benefit Lookup Portal is now available on the Local 831 Trust Funds website. This is a self-service portal that enables you, the Participant, to view your information in a few key areas. The specifics of what information you can view varies slightly depending on your status, but generally includes contact information, work history and the status of benefits such as health coverage. We are enclosing a User's Guide for your reference.

SUMMARIES OF BENEFITS AND COVERAGE

Enclosed you will find the following:

2026 Summary of Benefit Coverage (SBCs) for the Indemnity Plan
2026 Summary of Benefit Coverage (SBCs) for the Kaiser Permanente Plan

The SBCs are documents required by the Affordable Care Act. These documents summarize the benefits under the Fund and are intended to help you compare benefits between different Plans and Plan Levels. Please note that we are required to use certain uniform terms and other language prescribed by the Affordable Care Act and applicable regulations in the SBCs, and some of the terms, definitions and other language my differ from what is set forth in the Fund's other benefit materials.

2026 SCHEDULE OF HOURS

	Level 1	Level 2	Level 3	Level 4
Benefit Credits / Hours Needed	140	120	100	80
***Hours needed x hourly contribution (primary) rate of $13.40**	1,876	1,608	1,340	1,072
Maximum hour bank you could earn	9,380	8,040	6,700	5,360

*The contribution rate of $13.40 is effective with the March 1, 2024 work month.
*Monthly hourly schedule effective eligibility month of January 1, 2026.

COBRA MONTHLY PREMIUMS

Level 1	Level 2	Level 3	Level 4
$1,876	$1,608.00	$1,340.	$1,072.00

*The above COBRA rates are effective with the Eligibility month of January 2026.

QUESTIONS? CALL:	
Southern California Local Union 831 Employer Health Fund www.localunion831trustfunds.com	(multi-lingual) (877) 572-7005 (626) 279-3080
Kaiser www.kp.org	(multi-lingual) (800) 464-4000 (Spanish) (800) 788-0616
Anthem Blue Cross of California www.anthem.com/ca	(800) 274-7767
Employee Assistance Program: Claremont EAP www.claremonteap.com	(800) 834-3773
Optum Rx www.optumrx.com	(800) 797-9791

IMPORTANT NOTICES

Many federal and state laws guide the administration of all health benefit plans. While the Fund's plan documents actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and the Plan, the Plan will prevail. If you have any questions about this section, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080.

Grandfathered Status Notice

The Southern California Local Union 831 – Employer Health Fund believes its Indemnity Plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As of February 1, 2018, its Kaiser Plan will no longer be a Grandfathered Plan. As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Trust Fund Office at (877) 572-7005 or at (626) 279-3080.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/grandfathered-health-plans-provisions-summary-chart.pdf. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Women's Health and Cancer Rights Act (WHCRA)

Your health plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including the following services:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your Plan will provide coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductible, copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080.

Newborn's and Mother's Health Protection Act
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider (physician), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

If any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require precertification or preauthorization from the Plan or the issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

The Mental Health Parity and Addiction Equity Act of 1996
The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law on September 26, 1996. MHPAEA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on 31 medical / surgical benefits. MHPAEA's provisions are subject to concurrent jurisdiction by the Department of Labor, the Treasury and the Health and Human Services.

The Department of Labor, the Treasury, and Health and Human Services issued interim regulations that interpret MHPAEA. The regulations clarify the statutory requirements and provide information valuable to employers and employees in understanding their obligations and rights under the law.

COBRA Continuation Coverage
COBRA continuation coverage provides for a temporary extension of coverage under this Plan. See the Summary Plan Description for an explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it, along with information on other coverage options that may cost less than COBRA continuation coverage.

HIPAA
The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires the Employer Health Fund to give you a notice that provides a clear, user friendly explanation of your rights with respect to your personal health information and the Health Fund's privacy practices. You can find this notice in the Summary Plan Description, or you can request a copy by contacting the Trust Fund Office.

Your Rights and Protections against Surprise Medical Bills
When you get emergency care, use an out-of-network air ambulance provider, or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. *If you believe you've been wrongly billed,* you may contact the federal government's No Surprises Help Desk at 1 (800) 985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website:https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Help Identify Fraudulent or Abusive claims
Protect your Trust Fund by identifying and reporting fraudulent or abusive claims!

What to look out for:

- Billing for services that were never provided.
- Billing for medically unnecessary services.
- Duplicate submission of claims for the same service or supply.
- Misrepresenting the service provided through:
  - Changing the service to a more expensive type of service.
  - Reporting the wrong diagnosis or service.
- Misrepresenting the dates, location or provider of the service.
- Soliciting, offering, or receiving a kick-back.
- Waiving or reducing deductibles/copayments.
- Intentionally omitting other coverage or supporting false injury claims for higher reimbursement levels.
- Shaping the diagnosis, treatment, and/or billing coding to fit plan reimbursement provisions, for example:
  - Plastic surgery “nose job’ billed as a deviated septum.
  - Altering the diagnosis code order for greater benefit.
  - Ordering tests inconsistent with diagnosis indicated.
  - Extensive testing for multiple family members.

If you identify any possible fraud or abuse in the claims submitted for services rendered for you or your eligible dependents, please notify the Trust Fund Office immediately.

If you have any questions, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080 and / or visit our website at www.localunion831trustfunds.com.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-572-7005. 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 1-877-572-7005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Individual, $600 / Family	Generally, you must pay all of the costs from provider 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. Child immunizations, prescription drugs, dental, vision, annual physical, and diagnostic care and preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, $25 for dependent dental coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$4,900 / Person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, when applicable, deductible and health care this plan does not cover.	Even though you pay these expenses, they do not count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (800) 274-7767 for a list of participating 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 for non-emergency claims, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	10% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**	Generic drugs	Retail-20% coinsurance Mail Order-10% coinsurance; deductible does not apply	Not covered	Must use Mail Order for all maintenance drugs after the first three fills at a retail pharmacy.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Maximums for non-contracted facilities: $2,900 in Los Angeles / Orange / San Diego $2,450 in Riverside / San Bernardino. $1,910 in San Luis Obispo / Santa Barbara / Kern. $2,340 in Ventura
	Physician/surgeon fees	10% coinsurance	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	----------none----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	10% coinsurance	20% coinsurance	10% coinsurance for out-of-network

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				emergency services provided by a provider licensed to provide emergency services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	----------none----------
	Inpatient services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Children not covered. Only Participants and their spouses are covered. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for these services and skilled nursing care, even if you transition between home health care, rehabilitation services, or a skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Rehabilitation services	10% coinsurance	50% coinsurance	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for this service together with home health care and rehabilitation services, even if you transition between home health care, rehabilitation services, or a skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				or denied if not covered.
	Durable medical equipment	10% coinsurance	20% coinsurance	Purchases in excess of $500 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Hospice services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	----------none----------
	Children's glasses	No charge; deductible does not apply	No charge; deductible does not apply	----------none----------
	Children's dental check-up	20% coinsurance; $25 dependent-only deductible applies	20% coinsurance; $25 dependent-only deductible applies	----------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
- Habilitation services
- Infertility Treatment
- Long–term care
- Non-emergency care when traveling outside the US
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

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

- Acupuncture, subject to payment and visit limits
- Bariatric Surgery, subject to prior authorization
- Chiropractic care, subject to copayment and visit limits
- Dental care (Adult); subject to dependent deductible and calendar year maximum
- Hearing aids, up to $800 per ear
- Private-duty nursing
- 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: 1-877-572-7005.

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com.

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 1-877-572-7005

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com.

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	**$300**
Specialist coinsurance	**$400**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1227
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1587**

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

The plan's overall deductible	**$300**
Specialist coinsurance	**$30**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$782
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1104**

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

The plan's overall deductible	**$300**
Specialist coinsurance	**$34**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-572-7005. 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 1-877-572-7005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Individual, $600 / Family	Generally, you must pay all of the costs from provider 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. Child immunizations, prescription drugs, dental, vision, annual physical, and diagnostic care and preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, $25 for dental coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$4,900 / Person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, when applicable, deductible and health care this plan does not cover.	Even though you pay these expenses, they do not count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (800) 274-7767 for a list of participating 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 for non-emergency claims, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	10% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**	Generic drugs	Retail-20% coinsurance Mail Order-10% coinsurance; deductible does not apply	Not covered	Must use Mail Order for all maintenance drugs after the first three fills at a retail pharmacy.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Maximums for non-contracted facilities: $2,900 in Los Angeles / Orange / San Diego $2,450 in Riverside / San Bernardino. $1,910 in San Luis Obispo / Santa Barbara / Kern. $2,340 in Ventura
	Physician/surgeon fees	10% coinsurance	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate	Emergency room care	10% coinsurance	10% coinsurance	----------none----------

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	10% coinsurance	20% coinsurance	10% coinsurance for out-of-network emergency services provided by a provider licensed to provide emergency services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	----------none----------
	Inpatient services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Children not covered. Only Participants and their spouses are covered. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for these services and skilled nursing care, even if you transition between home health care, rehabilitation services, or skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Rehabilitation services	10% coinsurance	50% coinsurance	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for this service together with home health care and rehabilitation services, even if you

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				transition between home health care, rehabilitation services, or a skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Durable medical equipment	10% coinsurance	20% coinsurance	Purchases in excess of $500 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Hospice services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	----------none----------
	Children's glasses	No charge; deductible does not apply	No charge; deductible does not apply	----------none----------
	Children's dental check-up	30% coinsurance; $25 deductible applies	30% coinsurance; $25 deductible applies	----------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
- Habilitation services
- Infertility Treatment
- Long–term care
- Non-emergency care when traveling outside the US
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

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

- Acupuncture, subject to payment and visit limits
- Bariatric Surgery, subject to prior authorization
- Chiropractic care, subject to copayment and visit limits
- Dental care (Adult); subject to deductible and calendar year maximum
- Hearing aids, up to $800 per ear
- Private-duty nursing
- Routine eye care (Adult)

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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 1-877-572-7005

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$400
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1227
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1587**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$782
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1104**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$34
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-572-7005. 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 1-800-572-7005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Individual, $600 / Family	Generally, you must pay all of the costs from provider 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. Child immunizations, prescription drugs, dental, vision, annual physical, and diagnostic care and preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, $25 for dental coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$4,900 / Person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, when applicable, deductible and health care this plan does not cover.	Even though you pay these expenses, they do not count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (800) 274-7767 for a list of participating 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 for non-emergency claims, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider 's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	10% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	10% coinsurance with diagnosis; no charge if routine	20% coinsurance with diagnosis; no charge if routine	When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**	Generic drugs	Retail-20% coinsurance Mail Order-10% coinsurance; deductible does not apply	Not covered	Must use Mail Order for all maintenance drugs after the first three fills at a retail pharmacy.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Maximums for non-contracted facilities: $2,900 in Los Angeles / Orange / San Diego $2,450 in Riverside / San Bernardino. $1,910 in San Luis Obispo / Santa Barbara / Kern. $2,340 in Ventura
	Physician/surgeon fees	10% coinsurance	20% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	----------none----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	10% coinsurance	20% coinsurance	10% coinsurance for out-of-network emergency services provided by a provider licensed to provide emergency services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	----------none----------
	Inpatient services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Children not covered. Only Participants and their spouses are covered. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for these services and skilled nursing care, even if you transition between home health care, rehabilitation services, or a skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Rehabilitation services	10% coinsurance	50% coinsurance	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per admission in total for this service together with home health care and rehabilitation services, even if you transition between home health care, rehabilitation services, or a skilled

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Durable medical equipment	10% coinsurance	20% coinsurance	Purchases in excess of $500 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Hospice services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	40% coinsurance; $25 deductible applies	40% coinsurance; $25 deductible applies	----------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
- Habilitation services
- Infertility Treatment
- Long–term care
- Non-emergency care when traveling outside the US
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

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

- Acupuncture, subject to payment and visit limits
- Bariatric Surgery, subject to prior authorization
- Chiropractic care, subject to copayment and visit limits
- Dental care (Adult); subject to deductible and calendar year maximum
- Hearing aids, up to $800 per ear
- Private-duty nursing
- 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: 1-877-572-7005

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

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 1-877-572-7005

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

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 provider s 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	$300
Specialist *[cost sharing]*	$400
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1227
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1587**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$782
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1104**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$34
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-572-7005. 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 1-877-572-7005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Individual, $600 / Family	Generally, you must pay all of the costs from provider 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?	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	$4,900 / Person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, when applicable, deductible and health care this plan does not cover.	Even though you pay these expenses, they do not count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (800) 274-7767 for a list of participating 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 for non-emergency claims, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	Not covered	Not covered	Not covered
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	When required by law, out-of-network diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	When required by law, out-of-network imaging will be treated as in-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**	Generic drugs	Not covered	Not covered	Not covered
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Maximums for non-contracted facilities: $2,900 in Los Angeles / Orange / San Diego $2,450 in Riverside / San Bernardino. $1,910 in San Luis Obispo / Santa Barbara / Kern. $2,340 in Ventura
	Physician/surgeon fees	20% coinsurance	40% coinsurance	When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	----------none----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	20% coinsurance	40% coinsurance	20% coinsurance for out-of-network emergency

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				services provided by a provider licensed to provide emergency services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered. When required by law, out-of-network physician/surgeon fees will be treated as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	----------none----------
	Inpatient services	20% coinsurance	40% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Children not covered. Only Participants and their spouses are covered. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 days per admission in total for these services and skilled nursing care, even if you transition between home health care, rehabilitation services, or a skilled nursing facility during that time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Rehabilitation services	20% coinsurance	50% coinsurance	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per admission in total for this service together with home health care and rehabilitation services, even if you transition between home health care, rehabilitation services, or a skilled nursing facility during that

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				time frame; must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Purchases in excess of $500 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Hospice services	20% coinsurance	40% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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
- Habilitation services
- Infertility Treatment
- Long –term care
- Non-emergency care when traveling outside the US
- Dental care (Adult)
- Routine foot care
- Services that are not medically necessary
- Weight loss programs

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

- Acupuncture, subject to payment and visit limits
- Bariatric Surgery, subject to prior authorization
- Chiropractic care, subject to copayment and visit limits
- Hearing aids, up to $800 per ear
- Private-duty nursing
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

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: 1-877-572-7005

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 877-572-7005

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

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 amount, 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	$300
Specialist *[cost sharing]*	$800
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2453
What isn't covered	
Limits or exclusions	$109
The total Peg would pay is	**$2862**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$168
What isn't covered	
Limits or exclusions	$4461
The total Joe would pay is	**$4929**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$68
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$5
The total Mia would pay is	**$505**

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

* For more information about limitations and exceptions, see the plan or policy document at www.localunion831trustfunds.com

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 https://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	$25 / visit	Not Covered	None
	Specialist visit	$40 / 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)	Retail: $15 / prescription; Mail order: $30 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	Retail: $30 / prescription; Mail order: $60 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	Retail: $30 / prescription; Mail order: $60 / prescription	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)	$25 / 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	$75 / visit	$75 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$25 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $25 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: $12 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $25 / visit	Not Covered	None
	Habilitation services	$25 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	No Charge	Not Covered	Limited to base-covered items in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

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

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

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

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

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

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

TRADITIONAL 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)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 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** **$40**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$60**

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** **$40**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$0**
- **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

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not 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 Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

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

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **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 Coordinator 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:

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

  California Department of Health Care Services Office of Civil Rights 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 of 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

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Notice of Language Assistance

English: ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese: 请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

KAISER PERMANENTE®

- Medicare，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- Medi-Cal：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP : با شماره **1-800-443-0815** (TTY **711**)از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese: ご注意。言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ទាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំ

ជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀត: **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

Korean: 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7일 오전 8시~오후 8시에 **1-800-443-0815** (TTY **711**) 번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7일, 하루 24시간
- 기타: **1-800-464-4000** (TTY **711**), 주 7일, 하루 24시간

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນເຊັ່ນອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສຳຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: GIHA. Tséé' naalkáah sidá'ígíí éí doo tł'éé' íił'į' dah sidáa'ígíí. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

KAISER PERMANENTE®

- Medicare, bikáa’ dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį́ t’ááłá’í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį́, 7 jį́ t’ááłá’í damóo
- T’áá ałʼąą: **1-800-464-4000** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį́, 7 jį́ t’ááłá’í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਏਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ:**1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (TTY **711**), без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (TTY **711**), круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000** (TTY **711**), круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), de 8 a. m. a 8 p. m., los 7 días de la semana.
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสาร เป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น.หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.

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TRADESHOW & SIGNCRAFTS
LOCAL UNION
831
Painters and Allied Trades District Council 36
Southern California

Visit our Website!

www.localunion831trustfunds.com

Visit our website's Participant Portal* for 24/7 access to:

- **Plan Information,**
- **Reference Materials,**
- **Forms,**
- **Important Notices, and**
- **Answers to Frequently Asked Questions**

Participant Portal Contents are limited to Plan Participants. To access the Participant Portal, please complete the registration form, by clicking the "Register" link located at the upper-right-hand corner of the website and completing the registration form.

Your registration will be reviewed during business hours and you will receive an email notification with your access as soon as your account is activated.

Participant Benefit Lookup Portal

Great News! The Participant Benefit Lookup Portal is now available. This is a self-service portal that enables you, the Participant, to view your information in a few key areas. The specifics of what information you can view varies slightly depending on your status, but generally includes contact information, work history, the status of benefits such as health coverage and pension credit accumulation, and, if you are a Retiree, your pension payment history. You'll be required to register for this portal in order to access your personal information. To register, visit: https://l831portal.pswadmin.com/registration

If you require assistance with your access, please send an email to gpwebmaster@pswadmin.com.

Participant Benefit Lookup Portal

User's Guide

https://l831portal.pswadmin.com/

If you require assistance with accessing the portal, email: qpwebmaster@pswadmin.com

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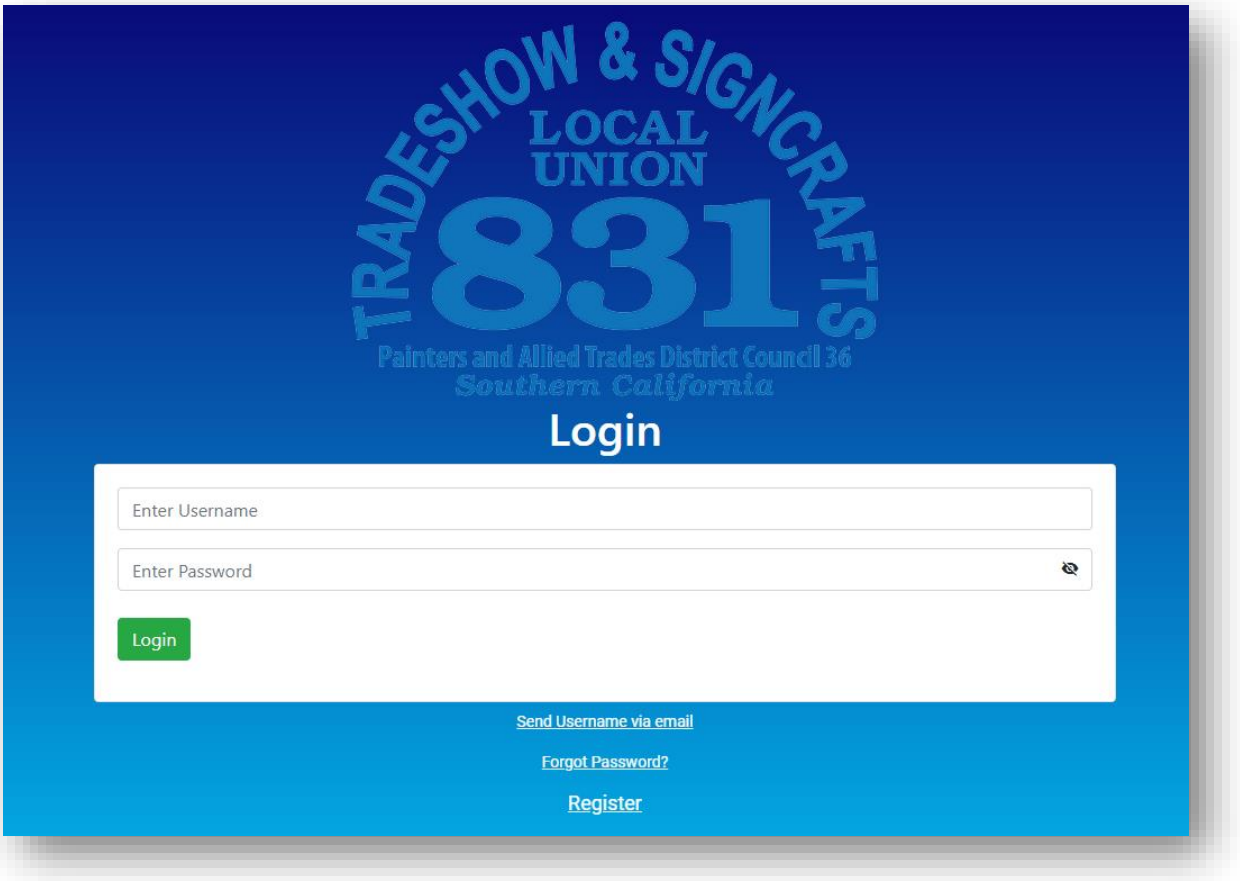
The Participant Benefit Lookup Portal

The Participant Benefit Lookup Portal (the "Portal") is a self-service portal that enables you, the participant, to view your information in a few key areas. The specifics of what information you can view varies slightly depending on your status, but generally includes contact information, work history, the status of benefits such as health coverage and pension credit accumulation, and, if you are a Retiree, your pension payment history.

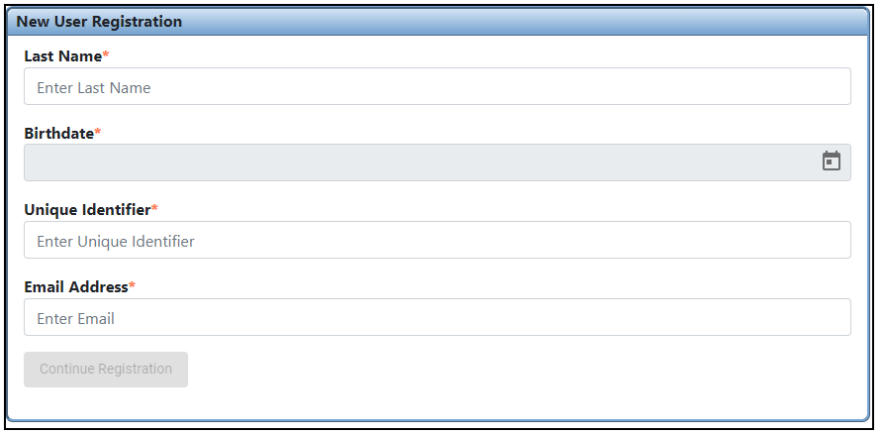
The Login Page

Upon navigating to the Portal, you will be directed to the Login Page. The Login Page allows existing users to log in and new users to register for the Portal and provides methods for you to access your account in the event you forget your username or password:



Registering for the Portal (New User)

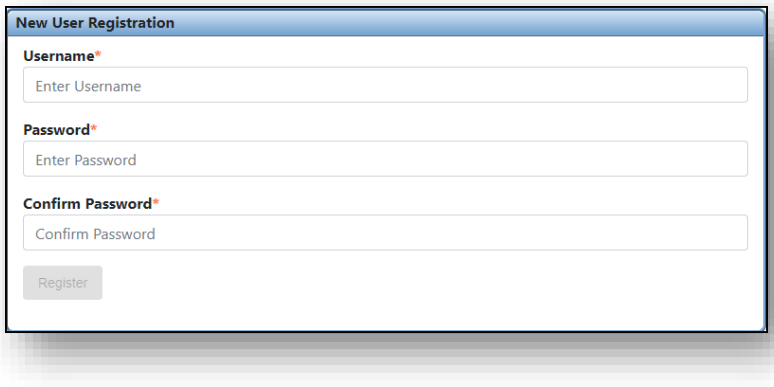
If you are new to the Portal, you must register before you can access your account. This is done by clicking "Register" on the Login Page. This brings up the following page, where the following fields will need to be completed:



Field Name	Field Description	Required
Last Name	The participant's last name must match the data on file with the Trust Fund Office or the participant will be unable to register.	Yes
Birthdate	The participant's date of birth must match the data on file with the Trust Fund Office or the participant will not be unable to register.	Yes
Unique Identifier*	The participant's 9-digit Unique Identifier (assigned by the Trust Fund Office). Must match the data on file with the Trust Fund Office or the participant will be unable to register.	Yes
Email Address	The participant's email address. This email will be used to verify/activate your account and provide a method of retrieving a forgotten username and resetting a forgotten password.	

* If you do not know your Unique ID, please contact the Trust Fund Office.

Upon completion of the above fields, click "Continue Registration" to proceed with the registration process. If the values in one or more of the above fields do not match the data on file with the Trust Fund Office, an error message will be displayed, and the fields indicated in red will need to be corrected. Once all fields are correctly filled out, clicking "Continue Registration" will direct you to the following page where the following fields will need to be completed:

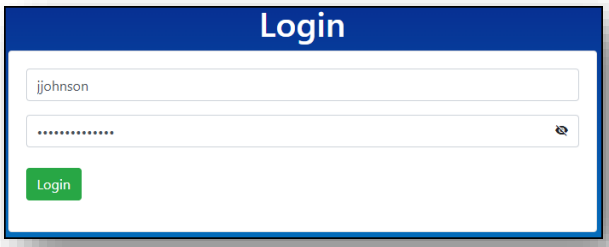


Field Name	Field Description	Required
Username	Choose a username. Usernames must be at least six characters long and cannot contain a space. Special characters allowed. Maximum 30 characters.	Yes
Password	Choose a password. Passwords must be 8- 30 characters long and contain at least one of each of the following: uppercase letter, lowercase letter, number, and special character (~`! @#$%^&* ()_-+= {|:;"'<,>.?/)	Yes
Confirm Password	Re-enter the password typed in the previous field. The Register button will not be enabled until these two fields match in value.	Yes

Once these fields have been filled out, click "Register". This will send a verification email to the email address given on the first registration page. From here, the participant should open the verification email and click the link contained within. They are then redirected to a confirmation page, after which registration is officially complete and the participant can log in to the Portal from the Login page.

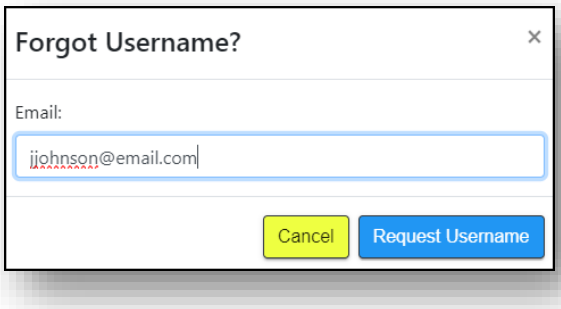
Logging in to the Portal (Existing User)

If you have already registered for the Portal, you can access the portal by logging in. They can do so by simply entering their Username and Password that they created during the registration process in the appropriate fields and clicking the "Login" button.



Accessing the Portal with a Forgotten Username (Existing User)

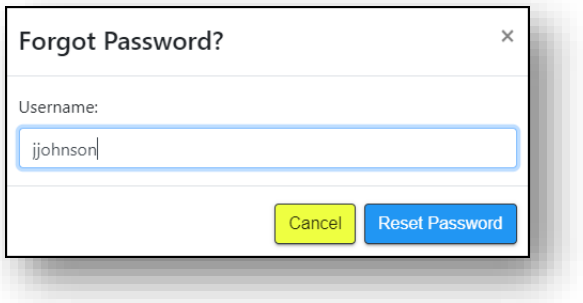
If you forget your Username for the Portal, you can retrieve it by clicking "Send Username via email". This will bring up the following pop-up window where you can enter the email address you used to register for the portal:



Once you've entered the correct email address, you can click "Request Username". This will send an email containing your portal Username to the indicated email address and enable you to log in without needing to change your password.

Accessing the Portal with a Forgotten Password (Existing User)

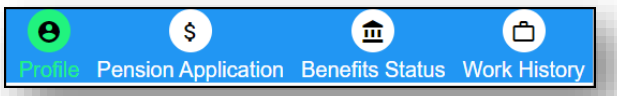
If you forget your password for the Portal, you can retrieve it by clicking "Forgot Password?". This will bring up the following pop-up window where the you can enter your Username:



Once you have entered your Username, you can click "Reset Password". This will send an email containing a password reset link to the email address you used to register for the portal. The link is valid for one hour and directs you to a screen where you can key and confirm a new password. This new password will still have the same requirements as the original one created during registration. After confirming the updated password, you will be redirected to the Login page.

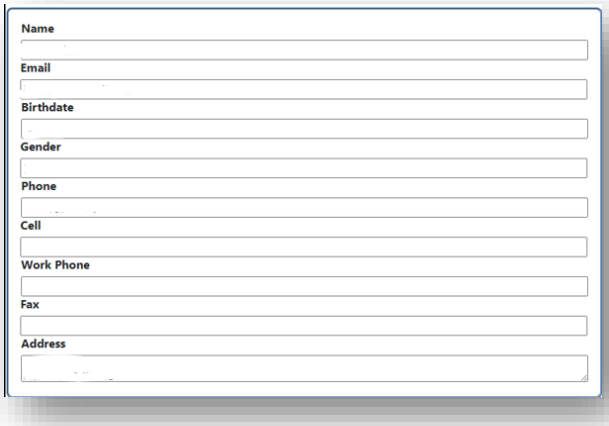
Navigating the Portal

Once you have logged in to the Portal, you can view your personal data across a series of screens. The exact combination of screens available to you depends on your circumstances (e.g., an Active participant may see a screen for their pension benefits accrual whereas a Retiree would see a screen displaying their pension payment history). You can navigate between these screens using the icons in the Navigation Bar, pictured here:



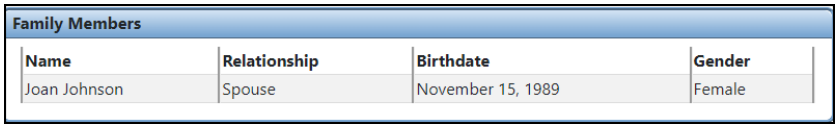
Profile

The Profile screen allows you to view various personal information, as it appears in the Trust Fund's records. The Profile screen is opened automatically upon logging in and appears as follows:



Field Name	Field Description
Name	Participant's first, last, middle name or initial (if present), and suffix (if applicable)
Email	Participant's email address, as it is listed in the Trust Fund's records. This may be different than email used to register for the Portal.
Birthdate	Participant's date of birth
Gender	Participant's gender
Phone	Participant's primary phone number (if given)
Cell	Participant's cell phone number (if given)
Work Phone	Participant's work phone number (if given)
Fax	Participant's fax number (if given)
Address	Participant's address

If you have any enrolled family members, their information will appear in a section of the Profile screen labeled "Family Members". The Family Members section appears as the below image and contains the following information for each enrolled family member:



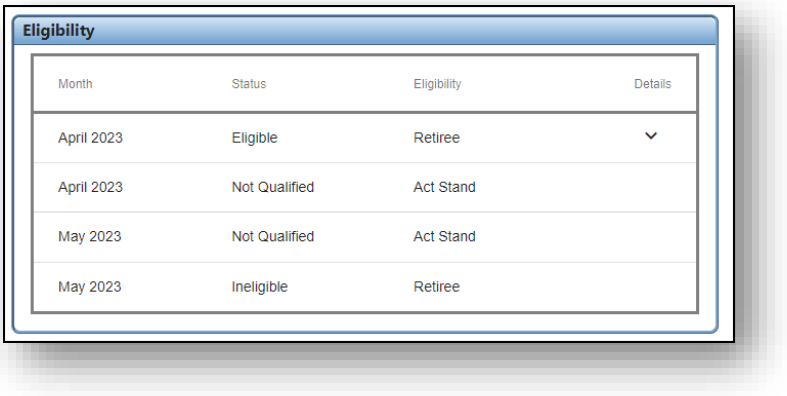
Field Name	Field Description
Name	Family member's first and last name
Relationship	Relationship to the participant (e.g., Spouse, Son, Daughter, etc.)
Birthdate	Family member's date of birth
Gender	Family member's gender

Benefits Status

The Benefits Status screen contains various information related to a participant's health coverage and pension status. It is divided into two sections, Eligibility and Pension Summary.

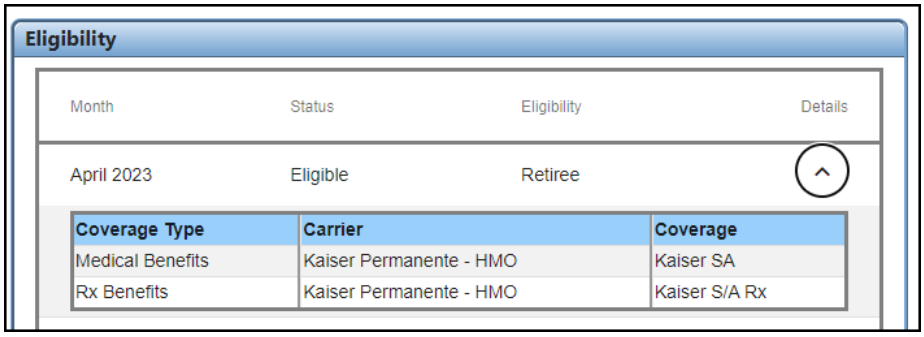
Eligibility

The Eligibility section of the Benefits Status screen contains eligibility information for the current and next eligibility months. This section is depicted in the following image and contains the fields below:



Field Name	Field Description
Month	Eligibility month and year
Status	Current eligibility status for the participant (e.g., Eligible, Ineligible, Not Qualified)
Eligibility	Type of eligibility for the specified coverage (e.g., Retiree, COBRA, Active Standard (Act Standard))
Details	A dropdown that provides coverage information. Only available when the status is Eligible.

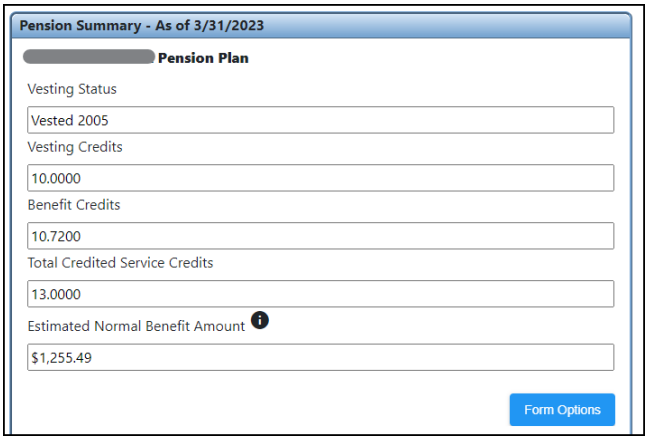
When you are eligible for a particular eligibility month, a Details dropdown becomes available that provides additional coverage information. This dropdown appears as follows and contains the below fields:



Field Name	Field Description
Coverage Type	The type of coverage offered by the plan (e.g., Medical Benefits, Rx Benefits, Dental Benefits, etc.)
Carrier	The carrier that provides the listed coverage (e.g., Kaiser, Anthem Blue Cross, etc.)
Coverage	System designation for the coverage provided by the plan (e.g., Kaiser HMO)

Pension Summary

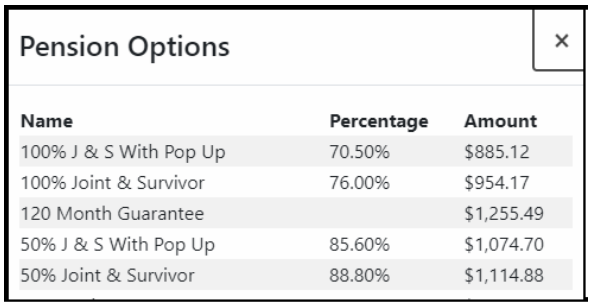
The Pension Summary section of the Benefits Status screen displays the active pension status of the participant as of a stated date, typically the end of the previous remittance cycle. This section is depicted in the following image and contains the fields below:



Field Name	Field Description
Vesting Status	Indicates whether the participant is Vested and, if so, displays the year in which they reached Vested status. This field will be blank if the participant has not reached Vested status.
Vesting Credits	Current accumulated vesting credits, as of the indicated date
Benefit Credits	Current accumulated benefit credits (also referred to as pension credits), as of the indicated date
Estimated Normal Benefit Amount	The estimated monthly benefit amount for the participant as of the indicated date

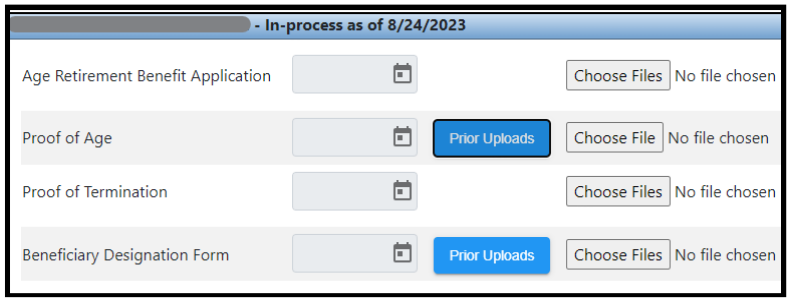
Pension Options

The "Form Options" button, when clicked, opens the Pension Options pop-up. This pop-up contains the various available pension forms, along with their respective benefit amounts for an individual with the same pension status as you, the participant. This pop-up is depicted in the following image:



Pension Application

If you have a pension application "In Process", you have access to the Pension Application screen. From here, you can upload required documents by clicking "Choose Files" next to any of the document fields, select a submission date, re-upload documents that have been rejected with comments (these comments are displayed to the far right of the row representing the rejected document), view previously uploaded document submissions by clicking "Prior Uploads", and submit the uploaded documents by clicking "Submit Documents". This screen is depicted in the following image:



Work History

The Work History screen displays your work history on file. Included below is an example of a Work History screen, along with some of the most common fields.

Agreement Name	Rate Variant	Work Period	Job Class	Reported Hours
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	08/2023	S	168.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	07/2023	S	192.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	06/2023	S	176.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	05/2023	S	168.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	04/2023	S	175.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	03/2023	S	196.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	02/2023	S	-175.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	02/2023	S	175.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	02/2023	S	-196.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	02/2023	S	196.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	02/2023	S	160.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	01/2023	S	176.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	12/2022	S	181.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	11/2022	S	160.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	10/2022	S	184.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	09/2022	S	176.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	08/2022	S	186.00
Service EEs International Union United Service Workers West	CONDO CEC OF SF	08/2022	S	8.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	07/2022	S	182.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	06/2022	S	168.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	05/2022	S	177.00
Service EEs International Union United Service Workers West	CONDO-CREST ROYAL APTS	04/2022	S	169.00

Field	Field Description
Employer Name	The full name of the employer that you worked under
Agreement Name	The full name of the agreement that you worked under
Work Period	The work month for the report in which the you appeared
Job Class	The reported job class that you worked under
Reported Hours	The hours reported on your behalf on the indicated report. When multiple hour types [Standard Time (ST), Overtime (OT), and Double-time (DT)] are recorded for the same job class, the number displayed here will be the sum of those hours.

Pension Payments

The Pension Payments screen contains a record of the pension payments issued to the participant. Please note that this screen is only visible to participants that are either actively being issued pension payments or have received such payments previously. A portion of this screen is depicted in the following image and contains the fields below:

Benefit Period	Issue Date	Payment Reference	Payment Type	Gross	FWT	SWT
07/2023	07/01/2023	EFT	EFT	1,225.46	0.0	0.0
06/2023	06/01/2023	EFT	EFT	1,225.46	0.0	0.0
05/2023	05/01/2023	EFT	EFT	1,225.46	0.0	0.0
04/2023	04/01/2023	EFT	EFT	1,225.46	0.0	0.0
03/2023	03/01/2023	EFT	EFT	1,225.46	0.0	0.0
02/2023	02/01/2023	EFT	EFT	1,225.46	0.0	0.0
01/2023	01/01/2023	EFT	EFT	1,225.46	0.0	0.0
12/2022	12/01/2022	EFT	EFT	1,225.46	0.0	0.0

Field Name	Field Description
Benefit Period	The benefit period for which the payment is being applied
Issue Date	The date the payment was issued
Payment Reference	A system reference for the payment. In the case of payment by check, this will be the check number, whereas an EFT payment will typically use "EFT" for this field.
Payment Type	The format of the payment (e.g., EFT, Check)
Gross	The gross amount of the payment (i.e., total amount before taxes and other deductions)
FWT	Federally Withheld Taxes
SWT	State Withheld Taxes
Health Premium	Deduction to cover the participant's monthly premium for health coverage (if applicable)
Adjustments	Contains any applicable adjustments made to the payment
Lien/Levy	Contains any applicable liens or levies on the payment
Net	Payment amount after taxes and other deductions
Payment Status	Status of the payment (e.g., Issued, Pending, etc.)

Documents

The Documents screen contains links that you can use to access various personal documents, such as benefit vouchers for retirees. The screen has sections for each document type that can be expanded to reveal a list of relevant documents, organized by date. For example, pension payment vouchers appear under the document type "Retiree Benefit Vouchers" and are organized and labeled by issue date. A portion of this screen is depicted in the following image:

