MFOW WELFARE FUND
240 2ND STREET
SAN FRANCISCO CA 94105

AUGUST 2025

TO: ALL PLAN PARTICIPANTS COVERED UNDER THE PHS REPLACEMENT PROGRAM HMO AND PPO MEDICAL AND PRESCRIPTION DRUG PLANS

RE: IMPORTANT NOTICE REGARDING YOUR HEALTH CARE COVERAGE ANNUAL SUMMARY OF BENEFITS COVERAGE FORM

Attached is a copy of the most recent Summary of Benefits Coverage Form outlining the Medical and Prescription Drug Plan benefits in which you are currently enrolled through the MFOW Welfare Benefit Plan and notices prepared by various providers highlighting some of the benefit changes for the year. The summary of changes outlined below, together with the enclosed Summary of Benefits Coverage Forms, constitute the "summary of material modifications" of the benefits provided under the medical plan options described in the Forms. Please keep this summary with your copy of the Summary Plan Description and your Evidence of Coverage.

If you wish to review the Summary of Benefits Coverage Forms for any of the other HMO/PPO plans and/or wish to make a change to one of the other HMO plans available to you, please contact the Welfare Fund Office (415) 986-1028 (240 Second Street, San Francisco, CA 94105). You have until September 30, 2025 to make any changes to your plan selection for an October 1, 2025 effective date. The following is a summary of the major Plan clarifications or changes (note that all benefits are subject to the terms of the plan document and applicable group insurance policy and Evidence of Coverage):

Kaiser Northern and Southern California: Effective October 1, 2025, benefit changes and contract clarifications will be effective on the renewal date.

1. Kaiser will implement coverage for doula services for pregnant women and develop a maternal and infant care services plan.

2. Coverage will be added for in vitro fertilization (IVF) in conjunction with Senate Bill 729. The Department of Managed Care is currently approving Kaiser's proposed benefits but we have been advised that coverage will include the following services:

    - Services required to diagnose infertility, including laboratory and imaging services
    - Services to treat infertility, including medications, artificial insemination, and in vitro fertilization

    Applicable cycle and/or benefit maximums are pending regulatory approval.
    Members will have the same cost share for fertility services (such as imaging or lab tests) as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for

fertility services will be applied to any out-of-pocket maximums for their benefit plan. Contact Member Services at kp.org/supportcenter or 1-800-464-4000 if you have any questions.

3. Medications prescribed strictly for the purpose of weight loss are generally excluded with one exception. These medications will be covered in the case of an individual who is morbidly obese.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

IMPORTANT NOTE TO KAISER EMPLOYEES RESIDING IN NORTHERN CALIFORNIA

You will be receiving a new Kaiser identification card in the mail which you should begin using at Northern California facilities starting October 1, 2025. When you receive your new Kaiser ID card, please destroy your current Kaiser card as the group number for your medical plan has changed from 102126 to 608193. Your medical record number will not change, and your Kaiser benefits will remain the same. If you happen to be in Southern California and need care, you will be able to use your new ID card as a visiting member. Please contact the Welfare Fund Office if you have any questions.

Kaiser Hawaii: Effective October 1, 2025, there are no contract changes for the medical and drug plans however the following two clarifications apply:

1. ***Maternity care postpartum visits***. Clarify that additional postpartum visits for maternity care are covered when medically necessary.

2. ***Physical, Occupational and Speech Therapy***. Clarify that therapy services for developmental delay are covered when medically necessary.

For details on your coverage, please refer to your Kaiser Permanente Hawaii's Guide to Your Health Plan that can be obtained from the Plan Office or Kaiser.

Note: the Kaiser Hawaii Dental plan will be terminated October 1, 2025 and replaced with a Blue Shield PPO dental plan. Further details will follow in a separate notice to be mailed in September 2025.

Kaiser Washington: Effective October 1, 2025, there are no substantial benefit changes nor contract clarifications effective on the renewal date.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Kaiser – Oregon Plan: Effective October 1, 2025 there are no substantial benefit changes nor contract clarifications effective on the renewal date.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Health Net HMO and PPO Plans: There will be several plan changes effective October 1, 2025.

1. HealthNet will implement coverage for doula services for pregnant women and develop a maternal and infant care services plan.

2. Coverage will be added for in vitro fertilization (IVF) in conjunction with Senate Bill 729.

    - Services required to diagnose infertility, including laboratory and imaging services
    - Services to treat infertility, including medications, artificial insemination, and in vitro fertilization

    Applicable cycle and/or benefit maximums are pending regulatory approval.

    Members will have the same cost share for fertility services (such as imaging or lab tests) as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.

Health Net PPO Plan Only

1. Coverage for self-injectable drugs will be provided under the Pharmacy benefit. Currently members pay a 30% coinsurance under the medical plan; there will be the same 30% coinsurance but each fill will be limited to a $250 maximum copayment.

2. The calendar year out-of-pocket maximum of $2,000 per individual currently applies to medical expenses only. Effective with the October 1, 2025 renewal, prescription drug out-of-pocket expenses for covered drugs will be added to the $2,000 maximum out of pocket amount.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Grandfathered Group Health Plans

The MFOW Welfare Fund's Board of Trustees has concluded that the HMOs are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). The HealthNet PPO plan, however, is a non-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 the 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 certain lifetime limits on benefits.

Although it is a "grandfathered health plan", you should know that the Plan provides health coverage/benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on required work hours. Nor does the Plan discriminate in favor of certain members based on compensation, age, gender, or health status.

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 plan administrator at (415) 986-1028. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

KAISER PERMANENTE® : HMO Group 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 1-800-966-5955 (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 1-800-966-5955 (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/ $4,500 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 1-800-966-5955 (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	$14/visit	Not Covered	None
	Specialist visit	$14/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	Inpatient fee included in hospital stay
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. Subject to formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. Subject to formulary guidelines. Certain drugs may be covered at a different cost share.
	Specialty drugs	$10 retail prescription	Not Covered	Up to 30-day retail. Certain drugs may be covered at a different cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$14/visit	Not Covered	None
	Physician/surgeon fees	No charge	Not Covered	Physican/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	$25/visit in-area; 20% coinsurance out-of-area	$25/visit in-area; 20% coinsurance out-of-area	Must notify KP within 48 hours if admitted to a non plan provider.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$14/visit	Not Covered	Non-plan providers covered when temporarily outside the service area: 20% coinsurance
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	$14/visit	Not Covered	None
	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	Professional services are included in the facility services
	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	Physician visit covered at primary care visit copay
	Rehabilitation services	$14/visit (outpatient); No Charge (inpatient).	Not Covered	None
	Habilitation services	Not covered	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	Limited to 120 days/benefit period
	Durable medical equipment	20% coinsurance; 50% coinsurance for Diabetic Supplies and Equipment	Not Covered	Subject to formulary guidelines.
	Hospice service	No Charge	Not Covered	Includes two 90-day periods, followed by unlimited number of 60-day periods
If your child needs dental or eye care	Children's eye exam	$14 / visit for refractive exam	Not Covered	Limited to 1 exam / year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture
- Children's dental check-up
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation Services
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling 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.)

- Bariatric Surgery
- Hearing Aids (Every 3 years)
- 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	1-800-966-5955 (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
Hawaii Department of Insurance	1-808-586-2790 or http://cca.hawaii.gov/ins/

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 1-800-966-5955 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-966-5955 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-966-5955 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-966-5955 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-966-5955 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-966-5955 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-966-5955 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-966-5955 (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** **$14**
- **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	$0
The total Peg would pay is	**$10**

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** **$14**
- **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	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$14**
- **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	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

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

If you need these services, call **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at **https://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice**