




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 toll-free at 888-865-5813 or visit [www.kp.org](http://www.kp.org). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://healthcare.gov/sbc-glossary> or call 770-997-9910 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$400 / individual or \$800 / family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive services</a> , <a href="#">emergency room care</a> , <a href="#">emergency medical transportation</a> , services subject to a <a href="#">copay</a> , <a href="#">prescription drugs</a> , <a href="#">home health care</a> , <a href="#">hospice services</a> , preventive dental services, and vision services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$150/visit for <a href="#">emergency room care</a> ; \$150/trip for <a href="#">emergency medical transportation</a> ; Dental services - \$25/individual or \$50/family. There are no other specific <a href="#">deductibles</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$4,000/individual, \$8,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Non-network provider</a> charges, <a href="#">premiums</a> , <a href="#">balance billing</a> , penalties for failure to obtain <a href="#">preauthorization</a> , infertility treatment, chiropractic services (except spinal manipulation), hearing aids, dental or vision services (except those covered under major medical), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-888-865-5813 for a list of Kaiser HMO <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and

Important Questions	Answers	Why This Matters:
		you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, written referral is required to see some <a href="#">specialists</a> . However, you may self-refer to obstetricians, gynecologists, dermatologists, psychiatrists, behavioral health specialists, optometrists, and ophthalmologists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge. <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge in office visit. <a href="#">Deductible</a> does not apply. 20% <a href="#">coinsurance</a> other outpatient setting	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug</a>	Generic drugs	Retail: \$6 copay/script at Kaiser, \$12 copay/script at Community Pharmacy; Mail Order: \$10 copay/script	Not covered	<a href="#">Deductible</a> does not apply. Coverage is limited to 30-day supply at retail. Coverage is limited to 31-90-day supply at mail order.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<a href="#">coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Preferred brand drugs	Retail: Greater of \$30 copay/script or 20% coinsurance at Kaiser, greater of \$36 copay/script or 20% coinsurance at Community Pharmacy; Mail Order: Lesser of \$100 copay/script or 15% coinsurance	Not covered	Coverage for designated Community Pharmacies is limited to one fill and then all refills must be obtained at Kaiser.  <a href="#">Preauthorization</a> is required for certain drugs. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
	Non-preferred brand drugs	Retail: Greater of \$40 <a href="#">copay</a> /script or 30% <a href="#">coinsurance</a> at Kaiser, greater of \$46 <a href="#">copay</a> /script or 30% <a href="#">coinsurance</a> at Community Pharmacy; Mail Order: Lesser of \$150 <a href="#">copay</a> /script or 25% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	Lesser of \$250 copay/script or 15% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit then 20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	A single \$150 <a href="#">deductible</a> will apply to both <a href="#">emergency room care</a> and <a href="#">emergency medical transportation</a> if same medical incident. If admitted to hospital from ER, the \$150 <a href="#">deductible</a> will only apply to transportation.
	<a href="#">Emergency medical transportation</a>	\$150/trip then 20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /visit in individual setting; \$12 <a href="#">copay</a> /visit co-pay in group setting; \$25 <a href="#">copay</a> /visit for drug monitoring. <a href="#">Deductible</a> does not apply. 20% <a href="#">coinsurance</a> for partial hospitalization	Not covered	None
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
If you are pregnant	Office visits	No charge. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> and <a href="#">deductible</a> may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge. <a href="#">Deductible</a> does not apply.	Not covered	Coverage is limited to 120 visits/year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 20 visits/year for physical and occupational therapy combined; 20 visits/year for speech therapy; 36 visits/year for cardiac rehabilitation. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 100 days/year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
	<a href="#">Hospice services</a>	No Charge. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , no benefits will be payable.
If your child needs dental or eye care	Children's eye exam	No Charge. <a href="#">Deductible</a> does not apply.	All charges in excess of \$30. <a href="#">Deductible</a> does not apply.	Limited to one exam/year. Not included in <a href="#">out-of-pocket limit</a> .
	Children's glasses	No Charge. <a href="#">Deductible</a> does not apply.	All charges in excess of \$35-\$75 (depending on lens type); \$56 (frames). <a href="#">Deductible</a> does not apply.	Limited to 1 set of glasses/year. Additional charges will apply for frames purchased from a <a href="#">network provider</a> over \$145 retail value or special coatings/tints to lenses. Not included in <a href="#">out-of-pocket limit</a> .
	Children's dental check-up	No Charge. <a href="#">Deductible</a> does not apply.	All charges over <a href="#">UCR</a> . <a href="#">Deductible</a> does not apply.	Limited to one exams/six months and \$1,500 annual maximum. Not included in <a href="#">out-of-pocket limit</a> .

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li> </ul>	<ul style="list-style-type: none"> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty Nursing</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care, limited to 25 visits/year</li> <li>Dental care (adult), limited to \$1,500 annual maximum</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids, limited to \$1,000/ear in a 36-month period</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> </ul>

**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](http://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](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the [plan](#) at 770-997-9910 or toll-free at 1-800-241-2136 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For insured dental and vision benefits, you can contact your State Department of Insurance. In Georgia, contact the Georgia Office of Insurance and Safety Fire Commissioner at 1-800-656-2298 or [www.oci.ga.gov/consumerservice/home.aspx](http://www.oci.ga.gov/consumerservice/home.aspx).

**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 1-888-865-5813

*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](#) \$400
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,430
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,900</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$820
<a href="#">Coinsurance</a>	\$620
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,440</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$550
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$360
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$990</b>

\* This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.