**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. 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: |
|---|---|---|
| **What is the overall deductible?** | $550 / individual or $1,100 / family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive services, emergency room care, emergency medical transportation, services subject to a copay, prescription drugs, home health care, hospice services, preventive dental services, and vision services 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. 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?** | Yes. $150/visit for emergency room care; $150/trip for emergency medical transportation; Dental services - $25/individual or $50/family. 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?** | $4,500 / individual, $9,000 / 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, balance billing, penalties for failure to obtain preauthorization, infertility treatment, chiropractic services (except spinal manipulation), hearing aids, dental or vision services (except those covered under major medical), and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.kp.org or call 1-888-865-5813 for a list of Kaiser HMO 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | 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, written referral is required to see some specialists. 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 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 | | 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 provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit. Deductible does not apply. | Not covered | $0 copay/visit for telemedicine visits with network providers |
| | Specialist visit | $40 copay/visit. Deductible does not apply. | Not covered | None |
| | Preventive care/screening/ immunization | No Charge. Deductible does not apply. | 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 in office visit. Deductible does not apply. 20% coinsurance other outpatient setting | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug** | Generic drugs | Retail: $6 copay/script at Kaiser, $12 copay/script at Community Pharmacy; Mail Order: $10 copay/ script | Not covered | Deductible 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) | |
| coverage is available at www.optumrx.com | 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.<br><br>Preauthorization is required for certain drugs. If you don't get preauthorization, no benefits will be payable. |
| | Non-preferred brand drugs | Retail: Greater of $40 copay/script or 30% coinsurance at Kaiser, greater of $46 copay/script or 30% coinsurance at Community Pharmacy; Mail Order: Lesser of $150 copay/script or 25% coinsurance | Not covered | |
| | Specialty drugs | Lesser of $250 copay/ script or 15% coinsurance | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $150/visit then 20% coinsurance | Covered as In-Network | A single $150 deductible will apply to both emergency room care and emergency medical transportation if same medical incident. If admitted to hospital from ER, the $150 deductible will only apply to transportation. |
| | Emergency medical transportation | $150/trip then 20% coinsurance | Covered as In-Network | |
| | Urgent care | $50 copay/visit. Deductible does not apply. | Not covered | Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency |

| 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) | |
| | | | | department may be covered as in-network. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit in individual setting; $12 copay/visit co-pay in group setting; $25 copay/visit for drug monitoring. Deductible does not apply. 20% coinsurance for partial hospitalization | Not covered | None |
| | Inpatient services | 20% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| **If you are pregnant** | Office visits | No charge. Deductible does not apply. | Not covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible 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% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge. Deductible does not apply. | Not covered | Coverage is limited to 120 visits/year. Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| | Rehabilitation services | 20% coinsurance | 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. Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| | Habilitation services | 20% coinsurance | Not covered | None |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 100 days/year. Preauthorization is required. If you don't get |

| 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) | |
| | | | | preauthorization, no benefits will be payable. |
| | Durable medical equipment | 20% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| | Hospice services | No Charge. Deductible does not apply. | Not covered | Preauthorization is required. If you don't get preauthorization, no benefits will be payable. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge. Deductible does not apply. | All charges in excess of $30. Deductible does not apply. | Limited to one exam/year. Not included in out-of-pocket limit. |
| | Children's glasses | No Charge. Deductible does not apply. | All charges in excess of $35-$75 (depending on lens type); $62 (frames). Deductible does not apply. | Limited to 1 set of glasses/year. Additional charges will apply for frames purchased from a network provider over $160 retail value or special coatings/tints to lenses. Not included in out-of-pocket limit. |
| | Children's dental check-up | No Charge. Deductible does not apply. | All charges over UCR. Deductible does not apply. | Limited to one exams/six months and $1,500 annual maximum. Not included in out-of-pocket limit. |

## 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
- Bariatric surgery
- Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Chiropractic care, limited to 25 visits/year
- Dental care (adult), limited to $1,500 annual maximum
- Hearing aids, limited to $1,000/ear in a 36-month period
- Infertility treatment, except for services related to artificial insemination or assisted reproductive technology procedures
- Routine eye care (Adult)
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

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

**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 | $550 |
| Specialist copayment | $40 |
| 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $550 |
| Copayments | $10 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,020** |

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

| | |
|---|---|
| The plan's overall deductible | $550 |
| Specialist copayment | $40 |
| 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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $830 |
| Coinsurance | $620 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,450** |

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

| | |
|---|---|
| The plan's overall deductible | $550 |
| Specialist copayment | $40 |
| 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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles* | $600 |
| Copayments | $90 |
| Coinsurance | $350 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,040** |

* 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.