




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? | \$1,250 / individual or \$2,500 / 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. 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? | \$6,500 / individual, \$13,000 / 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 | 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: |
|--|--|---|
| use a network provider ? | | 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 | \$30 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. 30% coinsurance other outpatient setting | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | 30% 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 \$35 copay/script or 25% coinsurance at Kaiser, greater of \$41 copay/script or 25% coinsurance at Community Pharmacy; Mail Order: Lesser of \$105 copay/script or 20% coinsurance | Not covered | Coverage for designated Community Pharmacies is limited to one fill and then all refills must be obtained at Kaiser. Preauthorization is required for certain drugs. If you don't get preauthorization , no benefits will be payable. |
| | Non-preferred brand drugs | Retail: Greater of \$45 copay /script or 35% coinsurance at Kaiser, greater of \$51 copay /script or 35% coinsurance at Community Pharmacy; Mail Order: Lesser of \$155 copay /script or 30% 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) | 30% coinsurance | Not covered | None |
| | Physician/surgeon fees | 30% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | \$150/visit then 30% 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 30% 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) | 30% coinsurance | Not covered | Preauthorization is required. If you don't get preauthorization , no benefits will be payable. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 copay /visit in individual setting; \$15 copay /visit co-pay in group setting; \$30 copay /visit for drug monitoring. Deductible does not apply. 30% coinsurance for partial hospitalization | Not covered | None |
| | Inpatient services | 30% 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 | 30% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 30% 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 | 30% 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 | 30% coinsurance | Not covered | None |
| | Skilled nursing care | 30% 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 | 30% 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 \$1,000 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 .) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law | <ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> 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.) | | |
| <ul style="list-style-type: none"> Chiropractic care, limited to 25 visits/year Dental care (adult), limited to \$1,000 annual maximum | <ul style="list-style-type: none"> Infertility treatment, except for services related to artificial insemination or assisted reproductive technology procedures | <ul style="list-style-type: none"> 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](#) \$1,250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,250 |
| Copayments | \$10 |
| Coinsurance | \$3,390 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,710 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$890 |
| Coinsurance | \$780 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,670 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles * | \$600 |
| Copayments | \$90 |
| Coinsurance | \$520 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,210 |

* 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.