




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 www.kp.org/plandocuments or call 1-888-865-5813 (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 1-888-865-5813 (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 Individual / \$6,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care and services indicated in chart starting on page 2.	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 ?	\$4,500 Self only enrollment; \$4,500 for any one member within a Family enrollment; \$9,000 for an entire 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 1-888-865-5813 (TTY:711) for a list of Plan 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		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan 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% coinsurance	Not covered	None
	Specialist visit	25% coinsurance	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)	X-ray: 25% coinsurance Lab tests: 25% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	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	\$10 (retail); \$20 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge, deductible does not apply for contraceptives. Subject to formulary guidelines.
	Preferred brand drugs	30% coinsurance up to \$100 (retail); 30% coinsurance up to \$200 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred brand drugs	50% coinsurance up to \$350 (retail); 50% coinsurance up to \$700 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Specialty drugs	50% coinsurance up to \$150 (retail) / 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% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	Not covered	Non-Plan Providers covered when temporarily outside the service area: 25% coinsurance .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	25% coinsurance	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance	Not covered	None
	Childbirth/delivery facility services	25% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	100 visit limit / year.
	Rehabilitation services	Outpatient: 25% coinsurance Inpatient: 25% coinsurance	Not covered	Outpatient: 60 visit limit / year. Limits combined with Habilitation services .
	Habilitation services	25% coinsurance	Not covered	60 visit limit / year. Limits combined with Rehabilitation services .
	Skilled nursing care	25% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	25% coinsurance	Not covered	Prior authorization required.
	Hospice services	25% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	25% coinsurance 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 .)		
• Acupuncture	• Dental care (Adult and child)	• Private-duty nursing
• Children's glasses	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• 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 (Under age 19: \$3,000 limit / ear / 48 months)	• Infertility treatment (3 in vitro procedure limit / lifetime)
• Chiropractic care (30 visit limit / year)		• 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	1-888-865-5813 (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
Georgia Department of Insurance	1-800-656-2298 or www.oci.ga.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 1-888-865-5813 (TTY: 711).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-865-5813 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-865-5813 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-865-5813 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-865-5813 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-865-5813 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-865-5813 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-865-5813 (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	\$6,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (blood work) coinsurance	25%

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
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$50
The total Peg would pay is	\$5,050

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (blood work) coinsurance	25%

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
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$3,000
Copayments	\$100
Coinsurance	\$600

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$3,700

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (x-ray) coinsurance	25%

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
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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