This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org or by calling **1-888-865-5813**.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Plan Provider **$500** individual / **$1,500** family; Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$150** individual / **$450** family for brand prescriptions; 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.
Is there an out-of-pocket limit on my expenses?	Yes. Plan Provider **$2,000** individual / **$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, deductibles, co-payments, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.kp.org **or call 1-888-865-5813** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **plan providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Events	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	Not covered	None
	Specialist visit	$35 co-pay/visit	Not covered	None
	Other practitioner office visit	Not covered	Not covered	None
	Preventive care/screening/immunization	No charge	Not Covered	Limited to 1 exam per year
If you have a test	Diagnostic test (x-ray, blood work)	No charge/office; 20% co-insurance after deductible outpatient setting	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible in office and outpatient setting	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.	Generic drugs (Kaiser/Community Pharmacy)	$10 co-pay/prescription at KP Pharmacy (retail and mail order); $20 co-pay/prescription at Network Pharmacy (retail)	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order) for 2 copayments at Kaiser Pharmacy only. Network Pharmacies limited to 1x refill
	Preferred brand drugs (Kaiser/Community Pharmacy)	$25 co-pay/prescription at KP Pharmacy (retail and mail order); $35 co-pay/prescription at Network Pharmacy (retail)	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order) for 2 copayments at Kaiser Pharmacy only. Network Pharmacies limited to 1x refill
	Non-preferred brand drugs (Kaiser/Community	Not covered	Not covered	None

Common Medical Events	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
	Pharmacy)			
	Specialty drugs (Kaiser/Community Pharmacy)	$25 co-pay/prescription at KP Pharmacy (retail and mail order); $35 co-pay/prescription at Network Pharmacy (retail)	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order) for 2 copayments at Kaiser Pharmacy only. Network Pharmacies limited to 1x refill
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	Not covered	None
	Physician/surgeon fees	20% co-insurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room services	$100 co-pay/visit	$100 co-pay/visit	Waived if admitted
	Emergency medical transportation	$100 co-pay/trip	$100 co-pay/trip	None
	Urgent care	$50 co-pay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible/admission	Not covered	None
	Physician/surgeon fee	20% co-insurance after deductible	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay per visit in individual settings; $17 co-pay per visit in group settings; $25 co-pay per visit for drug monitoring	Not covered	20 visits per year combined with Mental Health Group therapy
	Mental/Behavioral health inpatient services	20% co-insurance after deductible/admission	Not covered	30 days per calendar year
	Substance use disorder outpatient services	Not covered	Not covered	None
	Substance use disorder inpatient services	Not covered	Not covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not covered	1 Postnatal visit
	Delivery and all inpatient services	20% co-insurance after deductible/admission	Not covered	None
If you need help recovering or have other	Home health care	No Charge	Not covered	120 visits limited per year; Private duty nursing not covered

Common Medical Events	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
special health needs	Rehabilitation services	20% co-insurance after deductible Physical & Occupational Therapy, Speech Therapy, and Cardiac Rehabilitation	Not covered	20 visits per year for Physical & Occupational Therapy combined and Speech Therapy; 36 visits per year for Cardiac Rehabilitation
	Habilitation services	20% co-insurance after deductible Physical & Occupational Therapy, Speech Therapy, and Cardiac Rehabilitation	Not covered	20 visits per year for Physical & Occupational Therapy combined and Speech Therapy; 36 visits per year for Cardiac Rehabilitation
	Skilled nursing care	20% co-insurance after deductible/per admission	Not covered	60 days limited per year
	Durable medical equipment	20% co-insurance after deductible	Not covered	None
	Hospice service	No Charge	Not covered	None
If your child needs dental or eye care	Eye exam	$35 co-pay/visit to include refractions	Not covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (unless prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Routine eye care (Adult)
- Routine foot care (with diabetes)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-865-5813. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Member Services at 1-888-865-5813, Monday through Friday, 7:00 AM to 7:00 PM. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal.
You may contact the State Department of Insurance at:
Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
800-656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx
Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court. You may contact the State Department of Insurance as shown above.

Language Access Services:

[Spanish (Espanol): Para obtener asistencia en Espanol, llame 1-888-865-5813.]

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

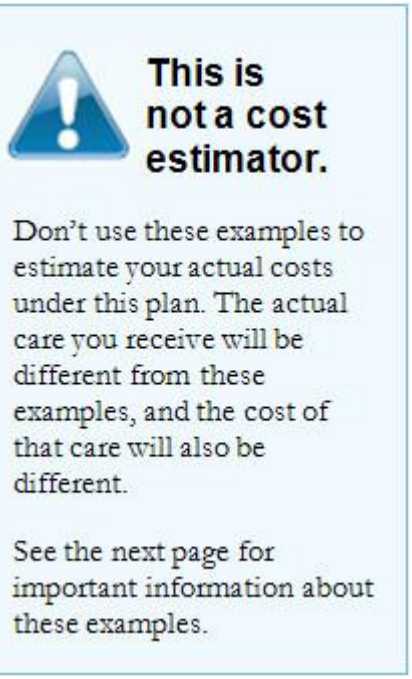
[Chinese 中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-865-5813.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-865-5813.]

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,020
- **Patient pays:** $1,520

Sample care costs:

Hospital Charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$20
Co-insurance	$800
Limits or exclusions	$200
Total	**$1,520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,420
- **Patient pays:** $980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$900
Co-insurance	$0
Limits or exclusions	$80
Total	**$980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don´t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren´t specific to a particular geographic area or health plan.
- The patient´s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn´t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor´s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are not cost estimators. You can´t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you´ll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you´ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.