




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 <https://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 <u>deductible</u> ?	\$5,250 Individual / \$10,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a copayment or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,350 Individual / \$14,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org or call 1-888-865-5813 (TTY: 711) for a list of <u>plan providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network providers</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, but you may self-refer to certain <u>specialists</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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)	Out-of-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	\$40 / visit. After Deductible (First 3 / visit deductible waived)	Not covered	None
	Specialist visit	\$60 / visit. After Deductible	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 you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance for Radiology regardless of setting; 40% coinsurance for LAB regardless of setting.	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance / scan regardless of 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/formulary .	Generic drugs	\$15 retail; \$25 network pharmacies; \$30 mail order / prescription	Not covered	Up to a 30 day supply (retail); Up to 90 day supply (mail order). Network Pharmacies limited to one time fill. No charge for contraceptives. Subject to formulary guidelines.
	Preferred brand drugs	\$50 retail; \$60 network pharmacies; \$100 mail order/ prescription	Not covered	Up to a 30 day supply (retail); Up to -90 day supply (mail order). Network Pharmacies limited to one time fill. After \$5,250 Individual / \$10,500 Family Rx Deductible for Brand, Non-Preferred and Specialty Drugs only.
	Non-preferred brand drugs	\$70 retail; \$80 network pharmacies; \$140 mail order/ prescription	Not covered	Up to a 30 day supply (retail); Up to -90 day supply (mail order). Network Pharmacies limited to one time fill. After \$5,250 Individual / \$10,500 Family Rx Deductible for Brand, Non-Preferred and Specialty Drugs only.
	Specialty drugs	30% coinsurance retail / network	Not covered	Up to a 30 day supply (retail); Up to -90 day supply (mail order). Network Pharmacies limited to one

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				time fill. After \$5,250 Individual / \$10,500 Family Rx Deductible for Brand, Non-Preferred and Specialty Drugs only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	Emergency room care	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Emergency medical transportation	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Urgent care	\$80 / visit. After <u>Deductible</u> (First 3 / visit deductible waived)	\$80 / visit. After <u>Deductible</u> (First 3 / visit deductible waived)	Non-participating <u>provider</u> covered when temporarily outside of our service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 / individual visit. <u>Deductible</u> does not apply; (First 3 / visit deductible waived)	Not covered	Mental/Behavioral health: \$20 / group visit. <u>Deductible</u> does not apply. Substance abuse: \$20 / group visit. <u>Deductible</u> does not apply.
	Inpatient services	40% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	40% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	40% <u>coinsurance</u>	Not covered	None
	Home health care	40% <u>coinsurance</u>	Not covered	120 visit limit / year. Private duty nursing not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: 40% <u>coinsurance</u> Inpatient: 40% <u>coinsurance</u>	Not covered	Outpatient: 40 visit limit / year combined for Occupational and Physical therapy. Speech therapy 40 visit limit / year
	Habilitation services	Outpatient: 40% <u>coinsurance</u> Inpatient: 40% <u>coinsurance</u>	Not covered	Outpatient: 40 visit limit / year combined for Occupational and Physical therapy. Speech therapy 40 visit limit / year
	Skilled nursing care	40% <u>coinsurance</u>	Not covered	150 day limit / year
	Durable medical equipment	40% <u>coinsurance</u>	Not covered	Coverage is unlimited to items on our DME formulary.
	Hospice services	No charge. <u>Deductible</u> does not apply.	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$40 / visit for refractive exam. <u>Deductible</u> does not apply.	Not covered	Coverage is limited to 1 exam per year.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	Not covered	Eye wear provided to children up to age 18. Coverage includes one pair of lenses & collection frames or contact lenses / year.
	Children's dental check-up	0% <u>coinsurance</u>	Not covered	Members age 18 and younger Pediatric Dental embedded.

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](#).)

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|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Children's glasses • Cosmetic surgery | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|--|---|--|
| <ul style="list-style-type: none"> • Chiropractic Care (20 visit limit / year spinal manipulation only) | <ul style="list-style-type: none"> • Dental care (Child) | <ul style="list-style-type: none"> • 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 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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)

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

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-865-5813 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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	\$5,250
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	40%
■ Other (blood work) coinsurance	40%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,300
Copayments	\$40
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,500

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$5,250
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	40%
■ Other (blood work) coinsurance	40%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,800
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$50
The total Joe would pay is	\$5,050

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,250
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	40%
■ Other (x-ray) coinsurance	40%

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-888-865-5813** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (TTY: **711**).

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-865-5813** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-865-5813 (TTY: 711) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-865-5813 (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-865-5813 (TTY: 711).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-865-5813 (TTY: 711).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-865-5813 (TTY: 711).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-865-5813 (TTY: 711) पर कॉल करें।

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-865-5813 (TTY: 711) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-865-5813 (TTY: 711) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiik'eh, éí ná hóló, kóíí' hódííłnih 1-888-865-5813 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-865-5813 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-865-5813 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-865-5813 (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-865-5813 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-865-5813 (TTY: 711).