
 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 ? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Not Applicable. | 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 ? | \$1,500 Individual / \$3,000 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 , 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 | \$20 / visit | Not covered | None |
| | Specialist visit | \$20 / visit | Not covered | None |
| | Preventive care/screening/immunization | No charge | 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: No charge Lab tests: No charge | Not covered | \$100 / visit in an outpatient setting. |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | \$100 / scan in an outpatient setting. |
| 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 (network pharmacy); \$20 (mail order) / prescription | Not covered | Up to a 30-day supply (retail & network pharmacies); up to a 90-day supply (mail order). Network Pharmacies limited to one-time fill. No charge for contraceptives. Subject to formulary guidelines. |
| | Preferred brand drugs | \$30 (retail); \$40 (network pharmacy); \$60 (mail order) / prescription | Not covered | Up to a 30-day supply (retail & network pharmacies); up to a 90-day supply (mail order). Network Pharmacies limited to one-time fill. Subject to formulary guidelines. |
| | Non-preferred brand drugs | \$30 (retail); \$40 (network pharmacy); \$60 (mail order) / prescription | Not covered | Up to a 30-day supply (retail & network pharmacies); up to a 90-day supply (mail order). Network Pharmacies limited to one-time fill. Subject to formulary guidelines, when approved through the exception process. |
| | Specialty drugs | Applicable Generic, Preferred brand or Non-preferred brand cost shares apply. | Not covered | Up to a 30-day supply (retail & network pharmacies). Network Pharmacies limited to one-time fill. Subject to formulary guidelines, when approved through the exception process. |

| 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 outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100 / visit | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | Physician/surgeon fees are included in the Facility fee. |
| If you need immediate medical attention | Emergency room care | \$100 / visit | \$100 / visit | Copayment waived if admitted directly to the hospital as an inpatient. |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | \$20 / visit | Not covered | Non-Plan Providers covered when temporarily outside the service area: \$20 / visit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 / admission | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | Physician/surgeon fees are included in the Facility fee. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 / individual visit | Not covered | \$10 / group visit. |
| | Inpatient services | \$250 / admission | Not covered | None |
| If you are pregnant | Office visits | No charge | Not covered | Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge | Not covered | Professional services are included in the facility services. |
| | Childbirth/delivery facility services | \$250 / admission | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | 100 visit limit / year. |
| | Rehabilitation services | Outpatient: \$20 / visit Inpatient: \$250 / admission | Not covered | None |
| | Habilitation services | \$20 / visit | Not covered | None |
| | Skilled nursing care | \$250 / admission | Not covered | 100-day limit / year. |
| | Durable medical equipment | No charge | Not covered | Subject to formulary guidelines. |
| | Hospice services | No charge | Not covered | None |

| 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 your child needs dental or eye care | Children's eye exam | \$20 / visit 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](#).)

- | | | |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Children's glasses • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult and child) • 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 |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|

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"> • Bariatric surgery • Chiropractic care (30 visit limit / year) | <ul style="list-style-type: none"> • Hearing aids (Adults: \$2,000 limit / ear / 36 months; under age 19: \$3,000 limit / ear / 48 months) | <ul style="list-style-type: none"> • Infertility treatment • 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).

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, 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, a'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 | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other (blood work) copayment | \$0 |

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 | \$0 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$350 |

Managing Joe's Type 2 Diabetes

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

| | |
|-----------------------------------------------------------------|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other (blood work) copayment | \$0 |

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 | \$1,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,000 |

Mia's Simple Fracture

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

| | |
|-----------------------------------------------------------------|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other (x-ray) copayment | \$0 |

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 | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$200 |

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

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
yáníti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá
jiiik'eh, éí ná hóló, kojí' hódíílnih **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).