



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, visit [www.shbp.georgia.gov](http://www.shbp.georgia.gov) or call 1-855-512-5997 (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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$6,350 You   \$12,700 You + Spouse or Child(ren)   12,700 You + Family   For <a href="#">out-of-network providers</a> : not covered.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.my.kp.org/shbp">www.my.kp.org/shbp</a> or call 1-855-512-5997 for a list of <a href="#">network providers</a> .	If you use a <a href="#">network</a> doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your <a href="#">network</a> doctor or hospital may use an <a href="#">out-of-network provider</a> for some services. Plans use the term in- <a href="#">network</a> , 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 you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, however you may self-refer to certain specialties. For other specialties, your PCP will coordinate any specialty care you might need. To select a PCP, visit <a href="http://www.my.kp.org/shbp">www.my.kp.org/shbp</a> .	This plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have the plan's permission before you see the <a href="#">specialist</a> .

\* For more information about limitations and exceptions, see the plan or policy document at <https://shbp.ga.gov>.



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /office visit	Not Covered	If you receive services in addition to an office visit, additional copayments may apply.
	<a href="#">Specialist</a> office visit	\$45 <a href="#">copay</a> /office visit	Not Covered	If you receive services in addition to an office visit, additional copayments may apply.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	Coverage is limited to 1 exam per year.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge for services performed in a Kaiser Permanente Medical Center or a free standing laboratory contracted with Kaiser Permanente; \$100 <a href="#">copay</a> for services performed in an outpatient hospital setting.	Not Covered	---None---
	Imaging (CT/PET scans, MRIs)	\$45 <a href="#">copay</a> for services performed in a Kaiser Permanente Medical Center or a free standing imaging center contracted with Kaiser Permanente; \$100 <a href="#">copay</a> for imaging performed in an outpatient hospital setting.	Not Covered	<a href="#">Preauthorization</a> may be required.

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.my.kp.org/shbp">prescription drug coverage</a> is available at <a href="http://www.my.kp.org/shbp">www.my.kp.org/shbp</a>	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> /prescription (retail); \$50 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$30 <a href="#">copay</a> per prescription ( <a href="#">network</a> pharmacies); <a href="#">Network</a> Pharmacies limited to one time fill. No charge for contraceptives (subject to formulary guidelines).
	Preferred brand drugs (Tier 2)	\$50 <a href="#">copay</a> /prescription (retail); \$125 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$60 <a href="#">copay</a> per prescription ( <a href="#">network</a> pharmacies); <a href="#">Network</a> Pharmacies limited to one time fill.
	Non-preferred brand drugs (Tier 3)	\$80 <a href="#">copay</a> /prescription (retail); \$200 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$90 <a href="#">copay</a> per prescription ( <a href="#">network</a> pharmacies); <a href="#">Network</a> Pharmacies limited to one time fill.
	<a href="#">Specialty drugs</a>	Same as Generic, Preferred, Non-preferred brand drugs, as applicable	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). Applicable <a href="#">copay</a> per prescription ( <a href="#">network</a> pharmacies); <a href="#">Network</a> Pharmacies limited to one time fill.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> /visit	Not Covered	---None---
	Physician/surgeon fees	Included in facility fee.	Not Covered	---None---
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit	\$200 <a href="#">copay</a> /visit	Waived if admitted
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a> /trip	\$100 <a href="#">copay</a> /trip	---None---
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit	Not Covered	Non-participating <a href="#">provider urgent care</a> covered only if you are temporarily outside of our service area. If you receive services in addition to an office visit, additional <a href="#">copays</a> may apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /admission	Not Covered	---None---
	Physician/surgeon fees	Included in facility fee	Not Covered	---None---

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> /visit (individual); \$17 <a href="#">copay</a> /visit group-Mental or Behavioral Health Services) \$35 <a href="#">copay</a> /visit (group-Substance Abuse Services)	Not Covered	If you receive services in addition to an office visit, additional <a href="#">copays</a> may apply.
	Inpatient services	\$250 <a href="#">copay</a> /admission	Not Covered	---None---
If you are pregnant	Office visits	No Charge	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Coverage is limited to 1 Postnatal visit. Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	\$250 <a href="#">copay</a> /admission	Not Covered	---None---
	Childbirth/delivery facility services	\$250 <a href="#">copay</a> /admission	Not Covered	---None---
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	Coverage is unlimited. Private duty nursing is not covered.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /visit (outpatient); \$250 <a href="#">copay</a> /admission (inpatient)	Not Covered	There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational and speech). Physical Therapy-additional visits may be covered if deemed medically necessary.

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)	
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> /visit; \$250 <a href="#">copay</a> /admission (inpatient)	Not Covered	There is a benefit maximum of 40 visits per therapy in a benefit year (physical, occupational and speech). Physical Therapy-additional visits may be covered if deemed medically necessary. These visits apply to the rehabilitation services limit.
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Skilled Nursing Facility 120 days per calendar year. No day limitations for Inpatient Rehab Facility.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> may be required.
	<a href="#">Hospice services</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> may be required. 8 bereavement visits per calendar year.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	1 routine exam every 24 months.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine Foot Care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
• Chiropractic care	• Routine eye care (Adult)	• Bariatric Surgery	• Hearing Aids

**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: Your state insurance department, Georgia Department of Insurance at 1-800-656-2298 or [www.oci.ga.gov/](http://www.oci.ga.gov/); or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage contact, the plan at 1-800-610-1863.

**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](#). You should contact Kaiser

Permanente Member Services directly to appeal denial of coverage for medical claims by calling 1-855-512-5997 (TTY: 711). For appeals related to wellness incentives, contact Kaiser Permanente HealthWorks at 1-866-300-9867. For questions about your eligibility, rights, this notice, or assistance, you can contact: the State Health Benefit Plan Member Services at 1-800-610-1863 or access information about eligibility appeals at [www.shbp.georgia.gov](http://www.shbp.georgia.gov). Your [plan](#) documents also provide complete information on how to [submit a claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

**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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$560</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,960</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$45
■ Hospital (facility) <a href="#">coinsurance</a>	\$0
■ Other <a href="#">coinsurance</a>	\$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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>

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