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 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 deductible? | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| 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? | For network providers $6,350 You\| $12,700 You + Spouse or Child(ren) \|12,700You + Family\| For out-of-network providers: not covered. | 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, balance-billing 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. |
| Will you pay less if you use a network provider? | Yes. See www.my.kp.org/shbp or call 1-855-512-5997 for a list of network providers. | If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your 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 you need a referral to see a specialist? | Yes, but you may self-refer to certain specialists.<br>No. Internal referrals to a Kaiser Permanente specialist do not require a written referral. | 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 . |

* 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 provider's office or clinic | Primary care visit to treat an injury or illness | $35 copay/office visit | Not Covered | If you receive services in addition to an office visit, additional copayments may apply. |
| | Specialist office visit | $45 copay/office visit | Not Covered | If you receive services in addition to an office visit, additional copayments may apply. |
| | Preventive care/screening/ immunization | No charge | Not Covered | Coverage is limited to 1 exam per year. |
| If you have a test | Diagnostic test (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 copay for services performed in an outpatient hospital setting. | Not Covered | --None-- |
| | Imaging (CT/PET scans, MRIs) | $45 copay for services performed in a Kaiser Permanente Medical Center or a free standing imaging center contracted with Kaiser Permanente; $100 copay for imagining performed in an outpatient hospital setting. | Not Covered | Preauthorization 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) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.my.kp.org/shbp | Generic drugs (Tier 1) | $20 copay/prescription (retail);<br>$50 copay/prescription (mail order) | Not Covered | Covers up to a 30 day supply (retail); 31-90 day supply (mail order). $30 copay per prescription (network pharmacies); Network Pharmacies limited to one time fill. No charge for contraceptives (subject to formulary guidelines). |
| | Preferred brand drugs (Tier 2) | $50 copay/prescription (retail);<br>$125 copay/prescription (mail order) | Not Covered | Covers up to a 30 day supply (retail); 31-90 day supply (mail order). $60 copay per prescription (network pharmacies); Network Pharmacies limited to one time fill. |
| | Non-preferred brand drugs (Tier 3) | $80 copay/prescription (retail);<br>$200 copay/prescription (mail order) | Not Covered | Covers up to a 30 day supply (retail); 31-90 day supply (mail order). $90 copay per prescription (network pharmacies); Network Pharmacies limited to one time fill. |
| | Specialty drugs | 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 copay per prescription (network pharmacies); Network Pharmacies limited to one time fill. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $100 copay/visit | Not Covered | ---None--- |
| | Physician/surgeon fees | Included in facility fee. | Not Covered | ---None--- |
| If you need immediate medical attention | Emergency room care | $150 copay/visit | $150 copay/visit | Waived if admitted |
| | Emergency medical transportation | $100 copay/trip | $100 copay/trip | ---None--- |
| | Urgent care | $35 copay/visit | Not Covered | Non-participating provider urgent care covered only if you are temporarily outside of our service area. If you receive services in addition to an office visit, additional copays may apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $250 copay/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 copay/visit (individual); $17 copay/visit group-Mental or Behavioral Health Services) $35 copay/visit (group-Substance Abuse Services) | Not Covered | If you receive services in addition to an office visit, additional copays may apply. |
| | Inpatient services | $250 copay/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 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 | $250 copay/admission | Not Covered | |
| | Childbirth/delivery facility services | $250 copay/admission | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Coverage is unlimited. Private duty nursing is not covered. |
| | Rehabilitation services | $25 copay/visit (outpatient); $250 copay/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) | |
| | Habilitation services | $25 copay/visit; $250 copay/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. |
| | Skilled nursing care | No Charge | Not Covered | Skilled Nursing Facility 120 days per calendar year. No day limitations for Inpatient Rehab Facility. |
| | Durable medical equipment | No Charge | Not Covered | Preauthorization may be required. |
| | Hospice services | No Charge | Not Covered | Preauthorization may be required. 8 bereavement visits per calendar year. |
| If your child needs dental or eye care | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Hearing Aids
- 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: Your state insurance department, Georgia Department of Insurance at 1-800-656-2298 or 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. 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. 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. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan.

### 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 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, kwiijigo 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 | $0 |
| Specialist copayment | $45 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $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 | $7,540 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $560 |

### 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 | $45 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $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 | $5,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Joe would pay is | $1,960 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $45 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $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 | $1,900 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $500 |

The plan would be responsible for the other costs of these EXAMPLE covered services.