



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 <http://dch.georgia.gov/shbp-plan-documents> or by calling 1-855-512-5997.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You do not have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Plan In-Network Providers: \$6,350 You \$12,700 You +Spouse or Child(ren) \$12,700 You + Family Out-of-Network Providers: Not Covered	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, non-Essential Health Benefits covered by this plan, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u> ?	Yes. For a list of In-Network Providers, see www.my.kp.org/SHBP or call 1-855-512-5997.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. Written approval is required to see most specialists.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan does not cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** payment of 20% would be \$200. This may change if you have not 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 In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider (In-Network)	Your Cost If You Use a Non Plan Provider (Out-of-Network)	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 Copayment/visit	Not Covered	If you receive services in addition to an office visit, additional copayments may apply.
	Specialist visit	\$45 Copayment/visit	Not Covered	If you receive services in addition to an office visit, additional copayments may apply.
	Other practitioner office visit	\$45 Copayment/visit	Not Covered	Coverage is limited to 20 visits per year for chiropractic services. Prior Authorization is also required for benefits provided for Applied Behavioral Analysis (\$35,000 annual limit; covered through age 10).
	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 Copayment for services performed in an outpatient hospital setting	Not Covered	---None---

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Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider (In-Network)	Your Cost If You Use a Non Plan Provider (Out-of-Network)	Limitations & Exceptions
If you have a test (continued)	Imaging (CT/PET scans, MRIs)	\$45 Copayment for services performed in a Kaiser Permanente Medical Center or a free standing imaging center contracted with Kaiser Permanente; \$100 Copayment when imaging is performed in outpatient hospital setting	Not Covered	Prior Authorization may be required.
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	\$20 Copayment per prescription(retail); \$50 Copayment per prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$30 Copayment per prescription (network pharmacies); Network Pharmacies limited to one time fill. No charge for contraceptives (subject to formulary guidelines).
	Preferred brand drugs	\$50 Copayment per prescription(retail); \$125 Copayment per prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$60 Copayment per prescription (network pharmacies); Network Pharmacies limited to one time fill.
	Non-preferred brand drugs	\$80 Copayment per prescription(retail); \$200 Copayment per prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). \$90 Copayment per prescription (network pharmacies); Network Pharmacies limited to one time fill.
	Specialty drugs	Same as Generic, Preferred and Non-preferred brand drugs, as applicable	Not Covered	Covers up to a 30 day supply (retail); 31-90 day supply (mail order). Applicable Copayment per prescription (network pharmacies); Network Pharmacies limited to one time fill.

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Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider (In-Network)	Your Cost If You Use a Non Plan Provider (Out-of-Network)	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 Copayment/visit	Not Covered	---None---
	Physician/surgeon fees	Included in facility fee	Not Covered	---None---
If you need immediate medical attention	Emergency room services	\$150 Copayment/visit	\$150 Copayment/visit	This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see If you have a hospital stay for inpatient cost sharing).
	Emergency medical transportation	\$100 Copayment/trip	\$100 Copayment/trip	---None---
	Urgent care	\$35 Copayment/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 Copayments may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 Copayment/admission	Not Covered	---None---
	Physician/surgeon fee	Included in facility fee	Not Covered	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 Copayment/visit (individual); \$17 Copayment/visit (group)	Not Covered	If you receive services in addition to an office visit, additional Copayments may apply.
	Mental/Behavioral health inpatient services	\$250 Copayment/admission	Not Covered	---None---
	Substance use disorder outpatient services	\$35 Copayment/visit (individual); \$35 Copayment/visit (group)	Not Covered	If you receive services in addition to an office visit, additional Copayments may apply.
	Substance use disorder inpatient services	\$250 Copayment/admission	Not Covered	---None---

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Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider (In-Network)	Your Cost If You Use a Non Plan Provider (Out-of-Network)	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits Coverage is limited to 1 postnatal visit.
	Delivery and all inpatient services	\$250 Copayment/admission	Not Covered	---None---
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage is unlimited. Private duty nursing not covered.
	Rehabilitation services	\$25 Copayment/visit (outpatient); \$250 Copayment/admission (inpatient)	Not Covered	Coverage is limited to 40 outpatient visits per year per therapy for Occupational, Physical, Speech therapy. Physical therapy - additional visits may be covered if deemed medically necessary.
	Habilitation services	\$25 Copayment/visit (outpatient); \$250 Copayment/admission (inpatient)	Not Covered	Coverage is limited to 40 outpatient visits per year per therapy for Occupational, Physical, Speech therapy.
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 120 days per year.
	Durable medical equipment	No Charge	Not Covered	Coverage is limited to items on our DME formulary.
	Hospice service	No Charge	Not Covered	---None---
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	1 routine exam every 24 months.
	Glasses	Not Covered	Not Covered	No coverage for glasses
	Dental check-up	Not Covered	Not Covered	No dental coverage

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This is not a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery (except for bariatric pilot program) Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Infertility treatment Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Long-term care Private-duty nursing Routine foot care Weight loss programs

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

- Chiropractic care (limitations may apply)
- Hearing aids (limitations may apply)
- Routine eye care (Adult)

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 1-800-610-1863. 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 medical claims under your plan, you may be able to **appeal** or file a **grievance**. You should contact Kaiser Permanente directly to appeal denial of coverage for medical claims by calling 1-855-512-5997 or 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, 1-800-656-2298. 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.dch.georgia.gov/shbp.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-641-4862.

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

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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.



This is not a cost estimator.

Do not use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,050
- Patient pays \$490

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	\$0
Copays	\$290
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$490

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

- Amount owed to providers: \$5,400
- Plan pays \$3,820
- Patient pays \$1,580

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
Copays	\$1,500
Coinsurance after deductible	\$0
Limits or exclusions	\$80
Total	\$1,580

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not 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, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not 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 cannot 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 will 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 will pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. 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.

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