All services are in-network only except in the case of a true emergency.

| Kiaser 2024 | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (NorCal SBC)(SoCal SBC) | (NorCal SBC)(SoCal SBC) |
| **Coverage basics** | | |
| Calendar year deductible | $0 | $1,600 single coverage<br>$3,200 if you cover any dependents |
| Annual out-of-pocket maximum | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover<br>any dependents |
| **Preventive Care Services** | | |
| Preventive Exams & Screenings | 100% covered | 100% covered |
| Well Baby & Immunizations | 100% covered | 100% covered |
| **Physician Services** | | |
| Office Visit & Urgent Care | $20 per visit | You pay 10% after<br>the deductible |
| Online Visit | $0 per visit | $0 per visit |
| Chiropractic Services | $15 per visit limited to 30 visits per year | You pay 10%<br>after the deductible<br>(limited to 30<br>visits per year) |
| **Hospital Medical Services** | | |
| Inpatient | $200 per admission | You pay 10% after<br>the deductible |
| Outpatient | $20 per procedure | You pay 10% after<br>the deductible |
| Lab & X-Ray | No charge | You pay 10% after<br>the deductible |
| Emergency | $100 per visit – waived<br>if admitted | You pay 10% after<br>the deductible |
| **Prescriptions (30-Day Retail / 100-Day Mail Order)** | | |
| Tier 1 - Generic | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| Tier 2 - Formulary Brand Name | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| Tier 3 - Non-Formulary Brand | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail<br>Mail order: exception<br>basis required<br><br>Applicable formulary brand<br>costs shares apply |
| Tier 4 - Specialty | $30 retail only | Retail only<br>30% after the medical deductible (max cost: $150) |

All services are in-network only except in the case of a true emergency.

| HMO | |
|---|---|
| Summary of Benefits and Coverage Documents (SBC) | |
| | (Hawaii HMO SBC) |
| Coverage basics | |
| Calendar year deductible | $0 |
| Annual out-of-pocket maximum | $2,500 single coverage<br>$7,500 if you cover any dependents |
| Preventive Care Services | |
| Preventive Exams & Screenings | 100% covered |
| Well Baby & Immunizations | 100% covered |
| Physician Services | |
| Office Visit | $20 per visit<br>(primary care: no charge for children 0-17) |
| Urgent Care | $20 per visit<br>(outside the service area: 20%) |
| Online Visit | $0 per visit |
| Chiropractic Services | $20 per visit limited to 12 visits per year<br>(combined with acupuncture) |
| Hospital Medical Services | |
| Inpatient | You pay 10% |
| Outpatient | You pay 10% |
| Lab & X-Ray | $10 per day |
| Emergency | $100 per visit – waived if admitted |
| Prescriptions (30-Day Retail / 100-Day Mail Order) | |
| Tier 1 - Generic | $10 retail / $20 mail order |
| Tier 2 - Formulary Brand Name | $35 retail / $70 mail order |
| Tier 3 - Non-Formulary Brand | Applicable brand and generic cost apply |
| Tier 4 - Specialty | $200 retail |

All services are in-network only except in the case of a true emergency.

| | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (Colorado SBC) | (Colorado SBC) |
| **Coverage basics** | | |
| Calendar year deductible | $0 | $1,600 single coverage<br>$3,200 if you cover any dependents |
| Annual out-of-pocket maximum | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover any dependents |
| **Preventive Care Services** | | |
| Preventive Exams & Screenings | 100% covered | 100% covered |
| Well Baby & Immunizations | 100% covered | 100% covered |
| **Physician Services** | | |
| Office Visit & Urgent Care | $20 per visit | You pay 10% after the deductible |
| Online Visit | $0 per visit | $0 per visit |
| Chiropractic Services | $15 per visit limited to 30 visits per year | You pay 10% after the deductible (limited to 30 visits per year) |
| **Hospital Medical Services** | | |
| Inpatient | $200 per admission | You pay 10% after the deductible |
| Outpatient | $20 per procedure | You pay 10% after the deductible |
| Lab & X-Ray | No charge | You pay 10% after the deductible |
| Emergency | $100 per visit – waived if admitted | You pay 10% after the deductible |
| **Prescriptions (30-Day Retail / 90-Day Mail Order)** | | |
| Tier 1 - Generic | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| Tier 2 - Formulary Brand Name | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| Tier 3 - Non-Formulary Brand | Applicable brand and generic cost shares apply | Medical deductible then:<br>$50 retail /<br>$100 mail order |
| Tier 4 - Specialty | Retail only<br>Applicable preferred brand cost shares apply | Retail only<br>30% after the medical deductible (max cost: $150) |

All services are in-network only except in the case of a true emergency.

| | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (Mid-Atlantic SBC) | (Mid-Atlantic SBC) |
| **Coverage basics** | | |
| **Calendar year deductible** | $0 | $1,600 single coverage<br>$3,200 if you cover any dependents |
| **Annual out-of-pocket maximum** | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover any dependents |
| **Preventive Care Services** | | |
| **Preventive Exams & Screenings** | 100% covered | 100% covered |
| **Well Baby & Immunizations** | 100% covered | 100% covered |
| **Physician Services** | | |
| **Office Visit & Urgent Care** | $20 per visit | You pay 10% after the deductible |
| **Online Visit** | $0 per visit | $0 per visit |
| **Chiropractic Services** | $15 per visit limited to 30 visits per year | You pay 10% after the deductible (limited to 30 visits per year) |
| **Hospital Medical Services** | | |
| **Inpatient** | $200 per admission | You pay 10% after the deductible |
| **Outpatient** | $20 per procedure | You pay 10% after the deductible |
| **Lab & X-Ray** | No charge | You pay 10% after the deductible |
| **Emergency** | $100 per visit – waived if admitted | You pay 10% after the deductible |
| **Prescriptions (30-Day Retail / 90-Day Mail Order)** | | |
| **Community pharmacy** | Tier 1: $25<br>Tier 2: $40 | Tier 1: $20<br>Tier 2: $40<br>Tier 3: $60 |
| **Tier 1 - Generic** | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| **Tier 2 - Formulary Brand Name** | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| **Tier 3 - Non-Formulary Brand** | Applicable preferred brand cost shares apply | Medical deductible then:<br>$50 retail /<br>$100 mail order |
| **Tier 4 - Specialty** | Retail only<br>Applicable generic or preferred brand cost shares apply | Retail only<br>30% after the medical deductible (max cost: $150) |

All services are in-network only except in the case of a true emergency.

| | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (Georgia SBC) | (Georgia SBC) |
| **Coverage basics** | | |
| **Calendar year deductible** | $0 | $1,600 single coverage<br>$3,200 if you cover any dependents |
| **Annual out-of-pocket maximum** | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover any dependents |
| **Preventive Care Services** | | |
| **Preventive Exams & Screenings** | 100% covered | 100% covered |
| **Well Baby & Immunizations** | 100% covered | 100% covered |
| **Physician Services** | | |
| **Office Visit & Urgent Care** | $20 per visit | You pay 10% after the deductible |
| **Online Visit** | $0 per visit | $0 per visit |
| **Chiropractic Services** | $20 per visit limited to 30 visits per year | You pay 10% after the deductible (limited to 30 visits per year) |
| **Hospital Medical Services** | | |
| **Inpatient** | $200 per admission | You pay 10% after the deductible |
| **Outpatient** | $20 per procedure | You pay 10% after the deductible |
| **Lab & X-Ray** | No charge | You pay 10% after the deductible |
| **Emergency** | $100 per visit – waived if admitted | You pay 10% after the deductible |
| **Prescriptions (30-Day Retail / 90-Day Mail Order)** | | |
| **Community pharmacy** | Tier 1: $25<br>Tier 2: $40 | Tier 1: $20<br>Tier 2: $40<br>Tier 3: $60 |
| **Tier 1 - Generic** | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| **Tier 2 - Formulary Brand Name** | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| **Tier 3 - Non-Formulary Brand** | Applicable brand and generic cost shares apply | Medical deductible then:<br>$50 retail /<br>$100 mail order |
| **Tier 4 - Specialty** | Retail only<br>Applicable preferred brand cost shares apply | Retail only<br>30% after the medical deductible (max cost: $150) |

All services are in-network only except in the case of a true emergency.

| | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (Pacific Northwest SBC) | (Pacific Northwest SBC) |
| **Coverage basics** | | |
| Calendar year deductible | $0 | $1,600 single coverage<br>$3,200 if you cover any dependents |
| Annual out-of-pocket maximum | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover any dependents |
| **Preventive Care Services** | | |
| Preventive Exams & Screenings | 100% covered | 100% covered |
| Well Baby & Immunizations | 100% covered | 100% covered |
| **Physician Services** | | |
| Office Visit & Urgent Care | $20 per visit | You pay 10% after the deductible |
| Online Visit | $0 per visit | $0 per visit |
| Chiropractic Services | $20 per visit limited to 30 visits per year | You pay 10% after the deductible (limited to 30 visits per year) |
| **Hospital Medical Services** | | |
| Inpatient | $200 per admission | You pay 10% after the deductible |
| Outpatient | $20 per procedure | You pay 10% after the deductible |
| Lab & X-Ray | No charge | You pay 10% after the deductible |
| Emergency | $100 per visit – waived if admitted | You pay 10% after the deductible |
| **Prescriptions (30-Day Retail / 90-Day Mail Order)** | | |
| Tier 1 - Generic | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| Tier 2 - Formulary Brand Name | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| Tier 3 - Non-Formulary Brand | Applicable brand and generic cost shares apply | Medical deductible then:<br>$50 retail /<br>$100 mail order |
| Tier 4 - Specialty | Applicable preferred brand cost shares apply | Retail only<br>30% after the medical deductible (max cost: $150) |

All services are in-network only except in the case of a true emergency.

| | HMO | HDHP with HSA |
|---|---|---|
| **Summary of Benefits and Coverage Documents (SBC)** | | |
| | (Washington SBC) | (Washington SBC) |
| **Coverage basics** | | |
| **Calendar year deductible** | $0 | $1,600 single coverage<br>$3,200 if you cover<br>any dependents |
| **Annual out-of-pocket maximum** | $1,500 per person<br>$3,000 family maximum | $3,200 single coverage<br>$6,400 if you cover<br>any dependents |
| **Preventive Care Services** | | |
| **Preventive Exams & Screenings** | 100% covered | 100% covered |
| **Well Baby & Immunizations** | 100% covered | 100% covered |
| **Physician Services** | | |
| **Office Visit & Urgent Care** | $20 per visit | You pay 10% after<br>the deductible |
| **Online Visit** | $0 per visit | $0 per visit |
| **Chiropractic Services** | $20 per visit limited to 30 visits per year | You pay 10%<br>after the deductible<br>(limited to 30 visits per year) |
| **Hospital Medical Services** | | |
| **Inpatient** | $200 per admission | You pay 10% after<br>the deductible |
| **Outpatient** | $20 per procedure | You pay 10% after<br>the deductible |
| **Lab & X-Ray** | No charge | You pay 10% after<br>the deductible |
| **Emergency** | $100 per visit – waived<br>if admitted | You pay 10% after<br>the deductible |
| **Prescriptions (30-Day Retail / 90-Day Mail Order)** | | |
| **Tier 1 - Generic** | $15 retail /<br>$30 mail order | Medical deductible then:<br>$10 retail /<br>$20 mail order |
| **Tier 2 - Formulary Brand Name** | $30 retail /<br>$60 mail order | Medical deductible then:<br>$30 retail /<br>$60 mail order |
| **Tier 3 - Non-Formulary Brand** | Applicable brand and generic cost shares apply | Medical deductible then:<br>$50 retail /<br>$100 mail order |
| **Tier 4 - Specialty** | Retail only<br>Applicable preferred<br>brand cost shares apply | Retail only<br>30% after the medical deductible (max cost: $150) |