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.** Please read the FEHB Plan brochure (RI 73-047) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 877-KP4-FEDS (877-574-3337, TTY: 711) to request a copy of either document.

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?	**$2,250** / person up to **$4,500** / family	The out-of-pocket limit, or catastrophic maximum, 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 other services outlined in the FEHB brochure.	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/feds or call 877-KP4-FEDS (877-574-3337, 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**.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	Not Covered	Copayment waived for children through age 4
	Specialist visit	$20 per visit	Not Covered	---none---
	Preventive care/screening/ immunization	No charge	Not Covered	---none---
If you have a test	Diagnostic test (X-ray, blood work)	No charge	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	$75 per procedure	Not Covered	---none---
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	$7 per prescription (Plan pharmacy); $17 per prescription (network pharmacy); $5 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Preferred brand drugs	$30 per prescription (Plan pharmacy); $50 per prescription (network pharmacy); $28 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Non-preferred brand drugs	$45 per prescription (Plan pharmacy); $65 per prescription (network pharmacy); $43 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Specialty drugs	$100 per prescription (Plan pharmacy); $150 per prescription (network pharmacy); $100 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 per surgery or procedure	Not Covered	Other than a provider's office
	Physician/surgeon fees	Included in Facility fee	Not Covered	Other than a provider's office

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, plus you may be balance billed)	
If you need immediate medical attention	Emergency room care	$100 per visit	$100 per visit	Waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	---none---
	Urgent care	$20 per visit	$20 per visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per admission	Not Covered	---none---
	Physician/surgeon fees	Included in Facility fee	Not Covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 per visit (group); $10 per visit (individual)	Not Covered	Copayment waived for children through age 4
	Inpatient services	$100 per 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	Included in Facility fee	Not Covered	---none---
	Childbirth/delivery facility services	No charge	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	---none---
	Rehabilitation services	$20 per visit (outpatient); $100 per admission (inpatient)	Not Covered	Outpatient services: Up to 30 visits per condition per year. Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. No visit limits on habilitative services for children until the end of the month they turn age 19.
	Habilitation services	$20 per visit (outpatient); $100 per admission (inpatient)	Not Covered	
	Skilled nursing care	$100 per admission	Not Covered	Limited to 100 days per calendar year
	Durable medical equipment	50% of our allowance	Not Covered	---none---
	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, plus you may be balance billed)	
If your child needs dental or eye care	Children's eye exam	Optometrist: $10 per visit	Not Covered	One routine eye exam each year with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses
	Children's glasses	No charge	Not Covered	Limited to select frames and contacts every 12 months
	Children's dental check-up	$30 per visit for preventive dental services	Not Covered	Preventive dental services are limited to twice per contract year

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (20 visits / year)
- Bariatric surgery
- Chiropractic care (20 visits / year)
- Dental care
- Hearing aids (Children) (For children to the end of the month of age 19: 1/ear/36 months)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information
- Routine eye care
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 877-KP4-FEDS (877-574-3337, TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 877-KP4-FEDS (877-574-3337, TTY: 711).

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 877-KP4-FEDS (877-574-3337, TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-KP4-FEDS (877-574-3337, TTY: 711).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 877-KP4-FEDS (877-574-3337, TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-KP4-FEDS (877-574-3337, 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** **$100**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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** **$100**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

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** **$100**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

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.** Please read the FEHB Plan brochure (RI 73-047) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 877-KP4-FEDS (877-574-3337, TTY: 711) to request a copy of either document.

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?	**$3,500** / person up to **$7,000** / family	The out-of-pocket limit, or catastrophic maximum, 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 other services outlined in the FEHB brochure.	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/feds or call 877-KP4-FEDS (877-574-3337, 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**.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	Not Covered	Copayment waived for children through age 17
	Specialist visit	$30 per visit	Not Covered	---none---
	Preventive care/screening/ immunization	No charge	Not Covered	---none---
If you have a test	Diagnostic test (X-ray, blood work)	No charge	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	$100 per procedure	Not Covered	---none---
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 per prescription (Plan pharmacy); $20 per prescription (network pharmacy); $8 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Preferred brand drugs	$40 per prescription (Plan pharmacy); $60 per prescription (network pharmacy); $38 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Non-preferred brand drugs	$60 per prescription (Plan pharmacy); $80 per prescription (network pharmacy); $58 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Specialty drugs	$150 per prescription (Plan pharmacy); $200 per prescription (network pharmacy); $150 per prescription (mail service)	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 per surgery or procedure	Not Covered	Other than a provider's office

For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-047) at www.kp.org/feds.

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, plus you may be balance billed)	
	Physician/surgeon fees	Included in Facility fee	Not Covered	Other than a provider's office
If you need immediate medical attention	Emergency room care	$150 per visit	$150 per visit	Waived if admitted as inpatient
	Emergency medical transportation	$100 per service	$100 per encounter	---none---
	Urgent care	$30 per visit	$30 per visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 per admission	Not Covered	---none---
	Physician/surgeon fees	Included in Facility fee	Not Covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 per visit (group); $20 per visit (individual)	Not Covered	Copayment waived for children through age 17
	Inpatient services	$500 per 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	Included in Facility fee	Not Covered	---none---
	Childbirth/delivery facility services	No charge	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	---none---
	Rehabilitation services	$30 per visit (outpatient); $500 per admission (inpatient)	Not Covered	Outpatient services: Up to 30 visits per condition per year. Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. No visit limits on habilitative services for children until the end of the month they turn age 19.
	Habilitation services	$30 per visit (outpatient); $500 per admission (inpatient)	Not Covered	
	Skilled nursing care	$500 per admission	Not Covered	Limited to 100 days per calendar year
	Durable medical equipment	50% of our allowance	Not Covered	---none---
	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, plus you may be balance billed)	
If your child needs dental or eye care	Children's eye exam	Optometrist: $20 per visit	Not Covered	One routine eye exam each year with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses
	Children's glasses	No charge	Not Covered	Limited to select frames and contacts every 12 months
	Children's dental check-up	$30 per visit for preventive dental services	Not Covered	Preventive dental services are limited to twice per contract year

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (20 visits / year)
- Bariatric surgery
- Chiropractic care (20 visits / year)
- Dental care (Adult)
- Hearing aids (Children) (For children to the end of the month of age 19: 1/ear/36 months)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information
- Routine eye care
- Routine foot care
- Weight loss programs

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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:

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

About these Coverage Examples:

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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** **$30**
- **Hospital (facility) copayment** **$500**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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** **$30**
- **Hospital (facility) copayment** **$500**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
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** **$30**
- **Hospital (facility) copayment** **$500**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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. Please read the FEHB Plan brochure (RI 73-047) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 877-KP4-FEDS (877-574-3337, TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** / person up to **$200** / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care and services indicated in chart starting on page 2	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?	**$4,000** / person up to **$8,000** / family	The out-of-pocket limit, or catastrophic maximum, 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 other services outlined in the FEHB brochure.	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/feds or call 877-KP4-FEDS (877-574-3337, 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.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 per visit. Deductible does not apply.	Not Covered	Copayment waived for children through age 4
	Specialist visit	$40 per visit. Deductible does not apply.	Not Covered	---none---
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not Covered	---none---
If you have a test	Diagnostic test (X-ray, blood work)	Lab: No charge. Deductible does not apply. X-ray: $40 per visit. Deductible does not apply.	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	$100 per procedure	Not Covered	---none---
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 per prescription (Plan pharmacy); $20 per prescription (network pharmacy); $8 per prescription (mail service). Deductible does not apply.	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Preferred brand drugs	$45 per prescription (Plan pharmacy); $65 per prescription (network pharmacy); $43 per prescription (mail service). Deductible does not apply.	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Non-preferred brand drugs	$65 per prescription (Plan pharmacy); $85 per prescription (network pharmacy); $63 per prescription (mail service). Deductible does not apply.	Not covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for preventive drugs, contraceptives, or oral chemotherapy drugs.

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, plus you may be balance billed)	
	Specialty drugs	$200 per prescription (Plan pharmacy); $250 per prescription (network pharmacy); $200 per prescription (mail service). Deductible does not apply.	Not Covered	Up to a 30-day supply; up to a 90-day supply of maintenance drugs for 2 copayments through mail order pharmacy. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 per surgery or procedure	Not Covered	Other than a provider's office
	Physician/surgeon fees	Included in Facility fee	Not Covered	Other than a provider's office
If you need immediate medical attention	Emergency room care	$150 per visit	$150 per visit	Waived if admitted as inpatient
	Emergency medical transportation	$100 per service	$100 per encounter	---none---
	Urgent care	$40 per visit. Deductible does not apply	$40 per visit. Deductible does not apply	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 per admission	Not Covered	---none---
	Physician/surgeon fees	Included in Facility fee	Not Covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 per visit (group); $30 per visit (individual). Deductible does not apply.	Not Covered	Copayment waived for children through age 4
	Inpatient services	$750 per admission	Not Covered	---none---
If you are pregnant	Office visits	No charge. Deductible does not apply.	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	Included in Facility fee.	Not Covered	---none---
	Childbirth/delivery facility services	$750 per admission	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, plus you may be balance billed)	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	---none---
	Rehabilitation services	$40 per visit. Deductible does not apply (outpatient); $750 per admission (inpatient)	Not Covered	Outpatient services: Up to 30 visits per condition per year. Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. No visit limits on habilitative services for children until the end of the month they turn age 19.
	Habilitation services	$40 per visit. Deductible does not apply (outpatient); $750 per admission (inpatient)	Not Covered	
	Skilled nursing care	$750 per admission	Not Covered	Limited to 100 days per contract year.
	Durable medical equipment	50% of our allowance	Not Covered	---none---
	Hospice services	No charge	Not Covered	---none---
If your child needs dental or eye care	Children's eye exam	$30 per visit. Deductible does not apply.	Not Covered	One routine eye exam each year with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses
	Children's glasses	No charge. Deductible does not apply.	Not Covered	Limited to select frames and contacts every 12 months
	Children's dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult & child)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (20 visits / year)
- Bariatric surgery
- Chiropractic care (20 visits / year)
- Hearing aids (Children) (For children to the end of the month of age 19: 1/ear/36 months)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information
- Routine eye care
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 877-KP4-FEDS (877-574-3337, TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 877-KP4-FEDS (877-574-3337, TTY: 711).

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 877-KP4-FEDS (877-574-3337, TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-KP4-FEDS (877-574-3337, TTY: 711).
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 877-KP4-FEDS (877-574-3337, TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-KP4-FEDS (877-574-3337, 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** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$750**
- **Other 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:

Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$750**
- **Other 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:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

- **The plan's overall deductible** **$100**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$750**
- **Other 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:

Cost Sharing	
Deductibles	$100
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, 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 **1-800-777-7902** (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 or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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 **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (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 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902**تماس بگیرید. (TTY: **711**)

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị.
Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

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。**1-800-777-7902**（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. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).