**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 73-004) 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 1-800-813-2000 (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?** | **$4,250** / person up to **$8,500** / 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 1-800-813-2000 (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 / visit; $0 / visit for children through age 17 | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| | Specialist visit | $30 / visit | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: $15 / visit<br>Blood work: $10 / visit | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| | Imaging (CT/PET scans, MRIs) | $100 / visit | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| **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 | $15 retail; $30 mail order | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Preferred brand drugs | $40 retail; $80 mail order | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Non-preferred brand drugs | $60 retail; $120 mail order | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Covered only when you meet formulary exception criteria. |
| | Specialty drugs | $100 retail | Not covered | Up to a 30-day supply. Subject to formulary guidelines. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 / admission | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| | Physician/surgeon fees | Included in Facility fee | Not covered | None |



For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-004) 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) | |
| **If you need immediate medical attention** | Emergency room care | $150 / visit | $150 / visit | You pay 10% coinsurance for drugs administered in connection with your care. Copayment waived if admitted directly to hospital as inpatient. |
| | Emergency medical transportation | $100 / trip | $100 / trip | None |
| | Urgent care | $35 / visit | $35 / visit | You pay 10% coinsurance for drugs administered in connection with your care. Non-plan providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 / 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 | $20 / visit; $0 / visit for children through age 17 | Not covered | You pay 10% coinsurance for drugs administered in connection with your care. |
| | Inpatient services | $250 / 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 / visit | Not covered | 20 visit / therapy / year. You pay 10% coinsurance for drugs administered in connection with your care. |



For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-004) 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) | |
| | Habilitation services | $30 / visit | Not covered | 20 visit / therapy / year. You pay 10% coinsurance for drugs administered in connection with your care. |
| | Skilled nursing care | No charge | Not covered | 100 days / year. |
| | Durable medical equipment | 20% coinsurance | Not covered | None |
| | Hospice services | No charge | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $20 / visit | Not covered | None |
| | Children's glasses | No charge | Not covered | Limited to select glasses or contacts every year. |
| | 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.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when travel 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 FEHB Plan brochure.)**

- Acupuncture ($1,000 max / year for all alternative care services combined)
- Bariatric surgery (Medically necessary)
- Chiropractic ($1,000 max / year / all alternative care services combined)
- Hearing aid (Through age 25: 1 aid / ear, every 36 months)
- Infertility treatment
- Routine Eye Care (Adult)

**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 1-800-813-2000 (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 FEHB Plan brochure. If you need assistance, you can contact: 1-800-813-2000 (TTY: 711).



For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-004) at www.kp.org/feds..

**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 1-800-813-2000 (TTY: 711).

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-813-2000 (TTY: 711).

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



For more information about limitations and exceptions, see the FEHB Plan brochure (RI 73-004) at www.kp.org/feds..

## 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]*** | **$30** |
| **Hospital (facility) *[copayment]*** | **$250** |
| **Blood work *[copayment]*** | **$10** |

**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 | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$150** |

### 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]*** | **$250** |
| **Blood work *[copayment]*** | **$10** |

**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 | $1,000 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,020** |

### 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]*** | **$250** |
| **X-ray *[copayment]*** | **$15** |

**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 | $500 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$550** |

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 73-004) 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 1-800-813-2000 (TTY: 711) to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$150** / person up to **$300** / 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?** | **$5,500** / person up to **$11,000** / 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 plan documents. | 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 or1-800-813-2000 (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 | $25 / visit; $0 / visit for children through age 17, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Specialist visit | $35 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: $30 / visit, deductible does not apply<br>Lab: $25 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Imaging (CT/PET scans, MRIs) | $150 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| **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 | $15 retail; $30 mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Preferred brand drugs | $50 retail; $100 mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Non-preferred brand drugs | $70 retail; $140 mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Covered only when you meet formulary exception criteria. |
| | Specialty drugs | $150 retail, deductible does not apply | Not covered | Up to a 30-day supply. Subject to formulary guidelines. |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 / admission | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Physician/surgeon fees | Included in Facility fee. | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $125 / visit | $125 / visit | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. Copayment waived if admitted directly to hospital as inpatient. |
| | Emergency medical transportation | $125 / trip | $125 / trip | None |
| | Urgent care | $40 / visit deductible does not apply | $40 / visit deductible does not apply | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. Non-plan providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $300 / 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 | $25 / visit; $0 / visit for children through age 17, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Inpatient services | $300 / 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 | 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 you need help recovering or have other special health needs** | Home health care | No charge | Not covered | None |
| | Rehabilitation services | $35 / visit, deductible does not apply | Not covered | 20 visit / therapy / year. You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Habilitation services | $35 / visit, deductible does not apply | Not covered | 20 visit / therapy / year. You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Skilled nursing care | No charge | Not covered | 100 days / year. |
| | Durable medical equipment | 20% coinsurance | Not covered | None |
| | Hospice services | No charge, deductible does not apply | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $25 / visit, deductible does not apply | Not covered | None |
| | Children's glasses | No charge, deductible does not apply | Not covered | Limited to select glasses or contacts every year. |
| | 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.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when travel 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 FEHB Plan brochure.)**

- Acupuncture ($1,000 max / year for all alternative care services combined)
- Bariatric surgery (Medically necessary)
- Chiropractic ($1,000 max / year for all alternative care services combined)
- Hearing aid (Through age 25: 1 aid / ear, every 36 months)
- Infertility treatment
- Routine Eye Care (Adult)

**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 1-800-813-2000 (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.

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**Does this plan provide Minimum Essential Coverage?** **Yes**

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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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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-813-2000 (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 | $150 |
| Specialist *[copayment]* | $35 |
| Hospital (facility) *[copayment]* | $300 |
| Blood work *[copayment]* | $25 |

**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 | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$250** |

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

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist *[copayment]* | $35 |
| Hospital (facility) *[copayment]* | $300 |
| Blood work *[copayment]* | $25 |

**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 | $1,200 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $150 |
| Specialist *[copayment]* | $35 |
| Hospital (facility) *[copayment]* | $300 |
| X-ray *[copayment]* | $30 |

**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 | $150 |
| Copayments | $600 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$800** |

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 73-004) 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 1-800-813-2000 (TTY: 711) to request a copy of either document.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$300** / person up to **$600** / 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?** | **$7,000** / person up to **$14,000** / 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 plan documents. | 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 1-800-813-2000 (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 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Specialist visit | $20 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $20 / visit | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Imaging (CT/PET scans, MRIs) | $100 / visit | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| **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 retail; $20 mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Preferred brand drugs | $50 retail; $100 mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. |
| | Non-preferred brand drugs | 40% coinsurance up to $350 max retail; 40% coinsurance up to $700 max mail order / prescription, deductible does not apply | Not covered | Up to a 30-day supply retail or 90-day supply mail order. Covered only when you meet formulary exception criteria. |
| | Specialty drugs | 40% coinsurance up to $500 max retail | Not covered | Up to a 30-day supply. Subject to formulary guidelines. |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $250 / admission | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Physician/surgeon fees | Included in Facility fee. | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $200 / visit | $200 / visit | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. Copayment waived if admitted directly to hospital as inpatient. |
| | Emergency medical transportation | $200 / trip | $200 / trip | None |
| | Urgent care | $30 / visit deductible does not apply | $30 / visit deductible does not apply | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. Non-plan providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 / 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 / visit, deductible does not apply | Not covered | You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Inpatient services | $500 / admission | Not covered | None |
| **If you are pregnant** | Office visits | $250 / admission | 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 |

| 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 | $20 / visit, deductible does not apply | Not covered | 20 visit / therapy / year. You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Habilitation services | $20 / visit, deductible does not apply | Not covered | 20 visit / therapy / year. You pay 20% coinsurance after the deductible for drugs administered in connection with your care. |
| | Skilled nursing care | No charge | Not covered | 100 days / year. |
| | Durable medical equipment | 20% coinsurance | Not covered | None |
| | Hospice services | No charge | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $10 / visit, deductible does not apply | Not covered | None |
| | Children's glasses | No charge, deductible does not apply | Not covered | Limited to select glasses or contacts every year. |
| | 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.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when travel 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 FEHB Plan brochure.)**

- Acupuncture ($1,000 max / year for all alternative care services combined)
- Bariatric surgery (Medically necessary)
- Chiropractic ($1,000 max / year for all alternative care services combined)
- Hearing aid (Through age 25: 1 aid / ear, every 36 months)
- Infertility treatment
- Routine Eye Care (Adult)

**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 1-800-813-2000 (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 FEHB Plan brochure. If you need assistance, you can contact: 1-800-813-2000 (TTY: 711).

**Does this plan provide Minimum Essential Coverage?** **Yes**

I 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 1-800-813-2000 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-813-2000 (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** | **$300** |
| **Specialist *[copayment]*** | **$20** |
| **Hospital (facility) *[copayment]*** | **$250** |
| **Blood work *[copayment]*** | **$20** |

**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 | $300 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$750** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist *[copayment]*** | **$20** |
| **Hospital (facility) *[copayment]*** | **$500** |
| **Blood work *[copayment]*** | **$20** |

**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 | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$920** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$300** |
| **Specialist *[copayment]*** | **$20** |
| **Hospital (facility) *[copayment]*** | **$500** |
| **X-ray *[copayment]*** | **$20** |

**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 | $300 |
| Copayments | $600 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$950** |

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

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Northwest (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 **1-800-813-2000** (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: Member Relations, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232, telephone number: 1-800-813-2000.

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.

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

**አማርኛ (Amharic) ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (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 **1-800-813-2000**（TTY：**711**）。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (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。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

**ខ្មែរ (Khmer) ប្រយ័ត្ន៖** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
**1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

**ລາວ (Laotian) ໂປດຊາບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

**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 **1-800-813-2000** (TTY: **711**).

**Afaan Oromoo (Oromo) XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa **1-800-813-2000** (TTY: **711**).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
**1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

**Română (Romanian) ATENȚIE:** Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).

**ไทย (Thai) เรียน:** ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

**Українська (Ukrainian) УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (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 **1-800-813-2000** (TTY: **711**).