



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 73-822) 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 1-800-278-3296 (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?	\$ 5,000 / person up to \$ 10,000 / 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 1-800-278-3296 (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 / visit, <u>deductible</u> does not apply.	Not covered	None
	<u>Specialist</u> visit	\$40 / visit, <u>deductible</u> does not apply.	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 / 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	\$15 retail; \$30 mail order / <u>prescription</u> , <u>deductible</u> does not apply.	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). No charge for contraceptives, <u>deductible</u> does not apply. Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	\$60 retail; \$120 mail order / <u>prescription</u> , <u>deductible</u> does not apply.	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred brand drugs	\$60 retail; \$120 mail order / <u>prescription</u> , <u>deductible</u> does not apply.	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Must be authorized through the exception drug process.
	<u>Specialty drugs</u>	\$200 / <u>prescription</u> , <u>deductible</u> does not apply.	Not covered	Up to 30-day supply. Subject to <u>formulary</u> guidelines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most, plus you may be balance billed)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 / procedure	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	\$150 / visit	\$150 / visit	<u>Copayment</u> waived if admitted directly to hospital as inpatient.
	<u>Emergency medical transportation</u>	\$200 / trip	\$200 / trip	None
	<u>Urgent care</u>	\$30 / visit, <u>deductible</u> does not apply.	Not covered	<u>Non-Plan providers</u> covered when temporarily outside the service area: \$30 / visit, <u>deductible</u> does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 / admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: \$30 / individual visit, <u>deductible</u> does not apply. Substance Abuse: \$30 / individual visit, <u>deductible</u> does not apply.	Not covered	Mental / Behavioral health: \$15 / group visit, <u>deductible</u> does not apply. Substance Abuse: \$5 / group visit, <u>deductible</u> does not apply.
	Inpatient services	\$750 / admission	Not covered	None
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply.	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	Professional services are included in the Facility fee.
	Childbirth/delivery facility services	\$750 / 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	<u>Home health care</u>	No charge, <u>deductible</u> does not apply.	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$30 / visit Inpatient: \$750 / admission	Not covered	None
	<u>Habilitation services</u>	Outpatient: \$30 / visit Inpatient: \$750 / admission	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	Up to 100 day limit / benefit period.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not covered	Prior authorization required
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply.	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, <u>deductible</u> does not apply.	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

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| <ul style="list-style-type: none"> • Cosmetic surgery • Chiropractic care • Dental care | <ul style="list-style-type: none"> • Eye glasses • Long-term care | <ul style="list-style-type: none"> • Private-duty nursing • Weight loss program |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

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| <ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery • Infertility treatment | <ul style="list-style-type: none"> • Hearing aid (\$1,000 limit / ear every 36 months) • Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information | <ul style="list-style-type: none"> • Routine eye care • Routine foot care |
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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 1-800-278-3296 (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: 1-800-278-3296 (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 1-800-788-0616 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (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 \$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$950

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 \$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$90
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$ 1,690

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 \$10

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$620