2022 PLANS AND PRODUCTS | MID-ATLANTIC STATES

Mid-size and Large Group plan comparison chart

Use this overview of our Mid-size and Large Group portfolio to easily explore a wide range of Kaiser Permanente plans. This interactive tool also enables you to get quick side-by-side comparisons of the different plans we have to offer.

Discover the Kaiser Permanente difference

Connected care. Plans that fit your budget.

At Kaiser Permanente, doctors, medical facilities, and health plan all work together to deliver care that's coordinated, proactive, and cost-efficient. Your employees get timely preventive screenings while avoiding unnecessary tests and procedures. You get a more engaged workforce that can help drive business success. And you can choose from a wide range of competitively priced plans to fit both your benefits strategy and your budget.

Compare plans quickly and easily

This section overviews an interactive plan comparison chart and time-saving quotes for our most popular standard Mid-size and Large Group plans—designed to meet your specific needs. With our Mid-size and Large Group portfolio, they're all at your disposal. You can easily compare core plan benefits as well as value-added supplemental benefits. And with a single request, you can get binding quotes in a matter of minutes for up to 1,000 members.

New in 2022—Virtual Complete™ plans

With a Kaiser Permanente Virtual Complete plan, your employees can get affordable, high-quality, personalized care in a variety of ways. They have flexibility in how they choose to get care—taking full advantage of our many no-cost virtual care options while still having access to in-person care whenever they need it.

Choice Products Portfolio

The new portfolio includes 6 new Added Choice plans and 2 new Flexible Choice plans.

2022 MAS plan pairings

To start, choose a single plan from Column 1. To view the entire plan pairing, choose the plan from Column 1 and check the "**See plan pairings"** box on the right.

See plan pairings

Column 1	Column 2 – Preferred Pairing	Column 3 – Acceptable Pairing
HMO	**Flexible Choice – Preferred Pairing**	**Flexible Choice – Acceptable Pairing**
☐ HMO/HMO Plus Plan 1	Flexible Choice Plan B	Flexible Choice Plan C
☐ HMO/HMO Plus Plan 2	Flexible Choice Plan C	Flexible Choice Plan G
☐ HMO/HMO Plus Plan 5	Flexible Choice Plan C	Flexible Choice Plan G
☐ HMO/HMO Plus Plan 8	Flexible Choice Plan D, Flexible Choice Plan F1A	Flexible Choice Plan H, Flexible Choice Plan F1B
☐ HMO/HMO Plus Plan 10	Flexible Choice Plan I	Flexible Choice Plan J
☐ HMO/HMO Plus Plan 11	Deductible Flexible Choice Plan S	Flexible Choice Plan I

Deductible HMO	Deductible Flexible Choice – Preferred Pairing	Deductible Flexible Choice – Acceptable Pairing
☐ DHMO/DHMO Plus Plan 1	Deductible Flexible Choice Plan R	Deductible Flexible Choice Plan S
☐ DHMO/DHMO Plus Plan 2	Deductible Flexible Choice Plan R	Deductible Flexible Choice Plan S
☐ DHMO/DHMO Plus Plan 5	Deductible Flexible Choice Plan S	Deductible Flexible Choice Plan Q
☐ DHMO/DHMO Plus Plan 7	Deductible Flexible Choice Plan Q	Deductible Flexible Choice Plan T
☐ DHMO/DHMO Plus Plan 9	Deductible Flexible Choice Plan Q	Deductible Flexible Choice Plan T
☐ DHMO/DHMO Plus Plan 10	Deductible Flexible Choice Plan Q	Deductible Flexible Choice Plan T
☐ DHMO/DHMO Plus Plan 11	Deductible Flexible Choice Plan S	Deductible Flexible Choice Plan Q
☐ DHMO/DHMO Plus Plan 14	Deductible Flexible Choice Plan T	Not applicable
☐ DHMO/DHMO Plus Plan 17	Deductible Flexible Choice Plan T	Not applicable
☐ DHMO/DHMO Plus Plan 18	Deductible Flexible Choice Plan T	Not applicable
☐ DHMO/DHMO Plus Plan 20	Deductible Flexible Choice Plan S	Deductible Flexible Choice Plan Q
☐ DHMO/DHMO Plus Plan 21	Deductible Flexible Choice Plan Q	Deductible Flexible Choice Plan T
☐ DHMO/DHMO Plus Plan 22	Deductible Flexible Choice Plan T	Not applicable

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2022 MAS plan pairings

To start, choose a single plan from Column 1. To view the entire plan pairing, choose the plan from Column 1 and check the "**See plan pairings"** box on the right.

See plan pairings

Column 1	Column 2 – Preferred Pairing	Column 3 – Acceptable Pairing
HSA-Qualified Deductible HMO	**Deductible Flexible Choice – Preferred Pairing**	**Deductible Flexible Choice – Acceptable Pairing**
☐ HSA-Qualified Deductible HMO Plan 1	HSA-Qualified Flexible Choice Plan U	HSA-Qualified Flexible Choice Plan V
☐ HSA-Qualified Deductible HMO Plan 2	HSA-Qualified Flexible Choice Plan U	HSA-Qualified Flexible Choice Plan V
☐ HSA-Qualified Deductible HMO Plan 3	HSA-Qualified Flexible Choice Plan V	Not applicable
☐ HSA-Qualified Deductible HMO Plan 4	HSA-Qualified Flexible Choice Plan V	Not applicable
☐ HSA-Qualified Deductible HMO Plan 16	HSA-Qualified Flexible Choice Plan U	HSA-Qualified Flexible Choice Plan V
☐ HSA-Qualified Deductible HMO Plan 17	HSA-Qualified Flexible Choice Plan V	Not applicable

Virtual Deductible HMO	Deductible/HSA Flexible Choice – Preferred Pairing	Deductible/HSA Flexible Choice – Acceptable Pairing
☐ Virtual Complete Deductible HMO Plan 1	Deductible Flexible Choice Plan T	HSA-Qualified Flexible Choice Plan V
☐ Virtual Complete Deductible HMO Plan 2	HSA-Qualified Flexible Choice Plan U	HSA-Qualified Flexible Choice Plan V
☐ Virtual Complete Deductible HMO Plan 3	HSA-Qualified Flexible Choice Plan V	Not applicable
☐ Virtual Forward Deductible HMO Plan 1	HSA-Qualified Flexible Choice Plan V	Deductible Flexible Choice Plan T
☐ Virtual Forward Deductible HMO Plan 2	HSA-Qualified Flexible Choice Plan V	HSA-Qualified Flexible Choice Plan U
☐ Virtual Forward Deductible HMO Plan 3	HSA-Qualified Flexible Choice Plan V	HSA-Qualified Flexible Choice Plan U

2022 MAS plan pairings

To start, choose a single plan from Column 1. To view the entire plan pairing, choose the plan from Column 1 and check the "**See plan pairings"** box on the right.

See plan pairings

Column 1	Column 2 – Preferred Pairing	Column 3 – Acceptable Pairing
HMO	**Added Choice – Preferred Pairing**	**Added Choice – Acceptable Pairing**
☐ HMO/HMO Plus Plan 1	Added Choice Plan 1	Added Choice Plan 2
☐ HMO/HMO Plus Plan 2	Added Choice Plan 1	Added Choice Plan 2
☐ HMO/HMO Plus Plan 5	Added Choice Plan 2	Added Choice Plan 3
☐ HMO/HMO Plus Plan 8	Added Choice Plan 3	Added Choice Plan 4
☐ HMO/HMO Plus Plan 10	Added Choice Plan 5	Added Choice Plan 6
☐ HMO/HMO Plus Plan 11	Added Choice Plan 3	Added Choice Plan 5

HMO			
Plan Options	**Plan 1**	**Plan 2**	**Plan 5**
Benefit/Feature	**Member pays**		
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	Not applicable	Not applicable
Deductible Accumulation	Not applicable		
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$1,300	$1,300	$1,300
Out-of-Pocket Maximum Accumulation	Embedded		
Office Visits–Primary Care	$10	$15	$20
Office Visits–Specialty Care	$20	$25	$30
Office Visits–Urgent Care	$20	$25	$30
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	No charge	$100	$300
Emergency Care (copay waived if admitted)	$100	$100	$100
Outpatient Surgery (facility fee)	No charge	$50	$75
Diagnostic Labs and X-rays	No charge	No charge	No charge
Special Diagnostic Procedures (CT, MRI, and PET scans)	No charge	$50	$75

HMO			
Plan Options	**Plan 8**	**Plan 10**	**Plan 11**
Benefit/Feature			
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	Not applicable	Not applicable
Deductible Accumulation	Not applicable		
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$2,250	$3,000
Out-of-Pocket Maximum Accumulation	Embedded		
Office Visits–Primary Care	$30	$30	$20
Office Visits–Specialty Care	$40	$40	$30
Office Visits–Urgent Care	$40	$40	$30
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	$100	$500	20%
Emergency Care (copay waived if admitted)	$100	$250	$250
Outpatient Surgery (facility fee)	$50	$100	20%
Diagnostic Labs and X-rays	No charge	No charge	$20
Special Diagnostic Procedures (CT, MRI, and PET scans)	$50	$100	$100

HMO PLUS		
Plan Options	**Plan 1**	
Benefit/Feature	**Member pays**	
	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	
Deductible Accumulation	Not applicable	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$1,300	Not applicable
Out-of-Pocket Maximum Accumulation	Embedded	Not applicable
Office Visits–Primary Care	$10	$30 (applies to 10-visit limit)
Office Visits–Specialty Care	$20	$40 (applies to 10-visit limit)
Office Visits–Urgent Care	$20	Not covered
Well-Child Care and Adult Preventive Services	No charge	No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	No charge	Not covered
Emergency Care (copay waived if admitted)	$100	Covered in-plan
Outpatient Surgery (facility fee)	No charge	Not covered
Diagnostic Labs and X-rays	No charge	$20 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	No charge	Not covered

HMO PLUS		
Plan Options	**Plan 2**	
Benefit/Feature	**Member pays**	
	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	
Deductible Accumulation	Not applicable	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$1,300	Not applicable
Out-of-Pocket Maximum Accumulation	Embedded	Not applicable
Office Visits–Primary Care	$15	$35 (applies to 10-visit limit)
Office Visits–Specialty Care	$25	$45 (applies to 10-visit limit)
Office Visits–Urgent Care	$25	Not covered
Well-Child Care and Adult Preventive Services	No charge	No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	$100	Not covered
Emergency Care (copay waived if admitted)	$100	Covered in-plan
Outpatient Surgery (facility fee)	$50	Not covered
Diagnostic Labs and X-rays	No charge	$20 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$50	Not covered

HMO PLUS		
Plan Options	**Plan 5**	**Plan 8**
Benefit/Feature	**Member pays**	
	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	
Deductible Accumulation	Not applicable	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$1,300/Not applicable	$2,250/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$20/$40 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Office Visits–Specialty Care	$30/$50 (applies to 10-visit limit)	$40/$60 (applies to 10-visit limit)
Office Visits–Urgent Care	$30/Not covered	$40/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	$300/Not covered	$100/Not covered
Emergency Care (copay waived if admitted)	$100/Covered in-plan	$100/Covered in-plan
Outpatient Surgery (facility fee)	$75/Not covered	$50/Not covered
Diagnostic Labs and X-rays	No charge/ $20 (applies to 10-visit limit)	No charge/ $20 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$75/Not covered	$50/Not covered

HMO PLUS		
Plan Options	**Plan 10**	**Plan 11**
Benefit/Feature	**Member pays**	
	In-Plan/ Out-of-Network	In-Plan/ Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	
Deductible Accumulation	Not applicable	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250/Not applicable	$3,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$30/$50 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Office Visits–Specialty Care	$40/$60 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Office Visits–Urgent Care	$40/Not covered	$30/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	$500/Not covered	20%/Not covered
Emergency Care (copay waived if admitted)	$250/Covered in-plan	$250/Covered in-plan
Outpatient Surgery (facility fee)	$100/Not covered	20%/Not covered
Diagnostic Labs and X-rays	No charge/ $20 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100/Not covered	$100/Not covered

DHMO					
Plan Options	**Plan 2**	**Plan 5**	**Plan 7**	**Plan 9**	**Plan 10**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$250	$500	$750	$1,000	$1,000
Deductible Accumulation	Embedded				
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$1,000	$3,000	$3,000	$3,000	$3,000
Out-of-Pocket Maximum Accumulation	Embedded				
Office Visits–Primary Care	$15	$20	$20	$20	$25
Office Visits–Specialty Care	$25	$30	$30	$30	$35
Office Visits–Urgent Care	$25	$30	$30	$30	$35
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Emergency Care (copay waived if admitted)	$100	$100	$100	$100	$100
Outpatient Surgery (facility fee)	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Diagnostic Labs and X-rays	$15	$20	$20	$20	$25
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible

DHMO					
Plan Options	**Plan 11**	**Plan 14**	**Plan 15**	**Plan 16**	**Plan 17**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$500	$1,500	$2,500	$2,500	$2,000
Deductible Accumulation	Embedded				
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000	$3,000	$5,000	$5,000	$4,000
Out-of-Pocket Maximum Accumulation	Embedded				
Office Visits–Primary Care	$20	$25	$25	$30	$25
Office Visits–Specialty Care	$30	$35	$35	$40	$35
Office Visits–Urgent Care	$30	$35	$35	$40	$35
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	No charge after deductible	$250 after deductible	$250 after deductible	20% after deductible	$250 after deductible
Emergency Care (copay waived if admitted)	$100	$150	$150	$150	$150
Outpatient Surgery (facility fee)	No charge after deductible	No charge after deductible	No charge after deductible	20% after deductible	No charge after deductible
Diagnostic Labs and X-rays	No charge	No charge	No charge	$30	No charge
Special Diagnostic Procedures (CT, MRI, and PET scans)	No charge after deductible	$100 after deductible	$100 after deductible	20% after deductible	$100 after deductible

DHMO					
Plan Options	**Plan 18**	**Plan 19**	**Plan 20**	**Plan 21**	**Plan 22**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,000	$3,000	$500	$1,000	$1,500
Deductible Accumulation	Embedded				
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000	$6,000	$3,000	$3,000	$4,000
Out-of-Pocket Maximum Accumulation	Embedded				
Office Visits–Primary Care	$25	$25	$20	$25	$20
Office Visits–Specialty Care	$35	$50	$30	$35	$40
Office Visits–Urgent Care	$35	$50	$30	$35	$40
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	20% after deductible	$500 after deductible	10% after deductible	$250 after deductible	20% after deductible
Emergency Care (copay waived if admitted)	$150	$150	$100	$100	$100
Outpatient Surgery (facility fee)	20% after deductible	No charge after deductible	10% after deductible	No charge after deductible	20% after deductible
Diagnostic Labs and X-rays	$25	No charge	$20	No charge	$20
Special Diagnostic Procedures (CT, MRI, and PET scans)	20% after deductible	$200 after deductible	10% after deductible	$100 after deductible	20% after deductible

DHMO					
Plan Options	**Plan 23**	**MV Plan 1[1]**	**MV Plan 2[1]**	**MV Plan 3[1]**	**MV Plan 4[1]**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$4,000	$4,500	$4,500	$5,000	$5,000
Deductible Accumulation		Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$6,000	$6,000	$6,000	$7,000	$8,500
Out-of-Pocket Maximum Accumulation		Embedded			
Office Visits–Primary Care	$25	$50	$50	$50	$50
Office Visits–Specialty Care	$50	$50	$50	$50	$80
Office Visits–Urgent Care	$50	$50	$50	$50	$80
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	20% after deductible	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100	40% after deductible	$250	40% after deductible	40% after deductible
Outpatient Surgery (facility fee)	20% after deductible	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Diagnostic Labs and X-rays	$25	40% after deductible	$50	40% after deductible	$50 (labs)/$150 (X-rays)
Special Diagnostic Procedures (CT, MRI, and PET scans)	20% after deductible	40% after deductible	$150	40% after deductible	40% after deductible

[1]MV = Minimum Value

VIRTUAL FORWARD				
Plan Options	**Plan 1**	**Plan 2**	**Plan 3**	**MV Plan 1**
Benefit/Feature	**Member pays**			
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,000	$3,000	$4,000	$5,000
Deductible Accumulation	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000	$6,000	$6,000	$8,500
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	No charge for the first visit; $50 after deductible for each visit thereafter	No charge for the first visit; $60 after deductible for each visit thereafter	No charge for the first visit; $70 after deductible for each visit thereafter	No charge for the first visit; $70 after deductible for each visit thereafter
Office Visits–Specialty Care	$70 after deductible	$75 after deductible	$90 after deductible	$90 after deductible
Office Visits–Urgent Care	$70 after deductible	$75 after deductible	$90 after deductible	$90 after deductible
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	$300 per day up to 3 days after deductible	$400 per day up to 3 days after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$200 after deductible	$250 after deductible	$300 after deductible	40% after deductible
Outpatient Surgery (facility fee)	$200 after deductible	$250 after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	$50 after deductible	$60 after deductible	$70 after deductible	$70 (labs)/$150 (X-rays)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$150 after deductible	$200 after deductible	20% after deductible	40% after deductible

VIRTUAL COMPLETE			
Plan Options	**Plan 1**	**Plan 2**	**Plan 3**
Benefit/Feature	**Member pays**		
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,000	$3,000	$4,000
Deductible Accumulation	Embedded		
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$5,000	$6,000	$8,000
Out-of-Pocket Maximum Accumulation	Embedded		
Office Visits–Primary Care	$30 for the first three visits; $30 after deductible for each visit thereafter	$40 for the first three visits; $40 after deductible for each visit thereafter	$50 for the first three visits; $50 after deductible for each visit thereafter
Office Visits–Specialty Care	$40 after deductible	$50 after deductible	$60 after deductible
Office Visits–Urgent Care	$40 after deductible	$50 after deductible	$60 after deductible
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	20% after deductible	30% after deductible	30% after deductible
Emergency Care (copay waived if admitted)	20% after deductible	30% after deductible	30% after deductible
Outpatient Surgery (facility fee)	20% after deductible	30% after deductible	30% after deductible
Diagnostic Labs and X-rays	$15 (labs)/20% after deductible (X-rays)	$30 (labs)/30% after deductible (X-rays)	$30 (labs)/30% after deductible (X-rays)
Special Diagnostic Procedures (CT, MRI, and PET scans)	20% after deductible	30% after deductible	30% after deductible

DEDUCTIBLE HMO PLUS

Plan Options	Plan 2	Plan 5	Plan 7
Benefit/Feature	Member pays		
	In-Plan/Out-of-Network	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$250/Not applicable	$500/Not applicable	$750/Not applicable
Deductible Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,000/Not applicable	$3,000/Not applicable	$3,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$15/$35 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Office Visits–Specialty Care	$25/$45 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Office Visits–Urgent Care	$25/Not covered	$30/Not covered	$30/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	10% after deductible/ Not covered	20% after deductible/ Not covered	20% after deductible/ Not covered
Emergency Care (copay waived if admitted)	$100/Covered in-plan	$100/Covered in-plan	$100/Covered in-plan
Outpatient Surgery (facility fee)	10% after deductible/ Not covered	20% after deductible/ Not covered	20% after deductible/ Not covered
Diagnostic Labs and X-rays	$15/$35 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible/ Not covered	20% after deductible/ Not covered	20% after deductible/ Not covered

DEDUCTIBLE HMO PLUS

Plan Options	Plan 9	Plan 10	Plan 11
Benefit/Feature	Member pays		
	In-Plan/Out-of-Network	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$1,000/Not applicable	$1,000/Not applicable	$500/Not applicable
Deductible Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000/Not applicable	$3,000/Not applicable	$3,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$20/$40 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Office Visits–Specialty Care	$30/ $50 (applies to 10-visit limit)	$35/ $55 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Office Visits–Urgent Care	$30/Not covered	$35/Not covered	$30/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	10% after deductible/ Not covered	20% after deductible/ Not covered	No charge after deductible/ Not covered
Emergency Care (copay waived if admitted)	$100/Covered in-plan	$100/Covered in-plan	$100/Covered in-plan
Outpatient Surgery (facility fee)	10% after deductible/ Not covered	20% after deductible/ Not covered	No charge after deductible/ Not covered
Diagnostic Labs and X-rays	$20/$40 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	No charge/$20 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible/ Not covered	20% after deductible/ Not covered	No charge after deductible/ Not covered

DEDUCTIBLE HMO PLUS

Plan Options	Plan 14	Plan 15	Plan 16
Benefit/Feature	Member pays		
	In-Plan/Out-of-Network	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$1,500/Not applicable	$2,500/Not applicable	$2,500/Not applicable
Deductible Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000/Not applicable	$5,000/Not applicable	$5,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$25/$45 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Office Visits–Specialty Care	$35/ $55 (applies to 10-visit limit)	$35/ $55 (applies to 10-visit limit)	$40/$60 (applies to 10-visit limit)
Office Visits–Urgent Care	$35/Not covered	$35/Not covered	$40/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	$250 after deductible/ Not covered	$250 after deductible/ Not covered	20% after deductible/ Not covered
Emergency Care (copay waived if admitted)	$150/Covered in-plan	$150/Covered in-plan	$150/Covered in-plan
Outpatient Surgery (facility fee)	No charge after deductible/ Not covered	No charge after deductible/ Not covered	20% after deductible/ Not covered
Diagnostic Labs and X-rays	No charge/$20 (applies to 10-visit limit)	No charge/$20 (applies to 10-visit limit)	$30/$50 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100 after deductible/ Not covered	$100 after deductible/ Not covered	20% after deductible/ Not covered

DEDUCTIBLE HMO PLUS

Plan Options	Plan 17	Plan 18	Plan 19
Benefit/Feature	**Member pays**		
	In-Plan/Out-of-Network	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,000/Not applicable	$2,000/Not applicable	$3,000/Not applicable
Deductible Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000/Not applicable	$4,000/Not applicable	$6,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$25/$45 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)
Office Visits–Specialty Care	$35/ $55 (applies to 10-visit limit)	$35/ $55 (applies to 10-visit limit)	$50/$70 (applies to 10-visit limit)
Office Visits–Urgent Care	$35/Not covered	$35/Not covered	$50/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	$250 after deductible/ Not covered	20% after deductible/ Not covered	$500 after deductible/ Not covered
Emergency Care (copay waived if admitted)	$150/Covered in-plan	$150/Covered in-plan	$150/Covered in-plan
Outpatient Surgery (facility fee)	No charge after deductible/ Not covered	20% after deductible/ Not covered	No charge after deductible/ Not covered
Diagnostic Labs and X-rays	No charge/$20 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	No charge/$20 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100 after deductible/ Not covered	20% after deductible/ Not covered	$200 after deductible/ Not covered

DEDUCTIBLE HMO PLUS

Plan Options	Plan 20	Plan 21	Plan 22
Benefit/Feature	**Member pays**		
	In-Plan/Out-of-Network	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$500/Not applicable	$1,000/Not applicable	$1,500/Not applicable
Deductible Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000/Not applicable	$3,000/Not applicable	$4,000/Not applicable
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded/Not applicable	Embedded/Not applicable
Office Visits–Primary Care	$20/40 (applies to 10-visit limit)	$25/$45 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Office Visits–Specialty Care	$30/$50 (applies to 10-visit limit)	$35/$55 (applies to 10-visit limit)	$40/$60 (applies to 10-visit limit)
Office Visits–Urgent Care	$30/Not covered	$35/Not covered	$40/Not covered
Well-Child Care and Adult Preventive Services	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)	No charge/ No charge (applies to 10-visit limit)
Inpatient Hospital Care (facility fee)	10% after deductible/ Not covered	$250 after deductible/ Not covered	20% after deductible/ Not covered
Emergency Care (copay waived if admitted)	$100/Covered in-plan	$100/Covered in-plan	$100/Covered in-plan
Outpatient Surgery (facility fee)	10% after deductible/ Not covered	No charge after deductible/ Not covered	20% after deductible/ Not covered
Diagnostic Labs and X-rays	$20/$40 (applies to 10-visit limit)	No charge/$20 (applies to 10-visit limit)	$20/$40 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible/ Not covered	$100 after deductible/ Not covered	20% after deductible/ Not covered

DEDUCTIBLE HMO PLUS		
Plan Options	**Plan 23**	**MV Plan 4**
Benefit/Feature	**Member pays**	
	In-Plan/Out-of-Network	In-Plan/Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$4,000/Not applicable	$5,000
Deductible Accumulation	Embedded/Not applicable	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$6,000/Not applicable	$8,500
Out-of-Pocket Maximum Accumulation	Embedded/Not applicable	Embedded
Office Visits–Primary Care	$25/$45 (applies to 10-visit limit)	$50/$70 (applies to 10-visit limit)
Office Visits–Specialty Care	$50/$70 (applies to 10-visit limit)	$80/$100 (applies to 10-visit limit)
Office Visits–Urgent Care	$50/Not covered	$80/Not covered
Well-Child Care and Adult Preventive Services	No charge/No charge (applies to 10-visit limit)	No charge
Inpatient Hospital Care (facility fee)	20% after deductible/ Not covered	40% after deductible/ Not covered
Emergency Care (copay waived if admitted)	$150/Covered in-plan	40% after deductible/ Covered in-plan
Outpatient Surgery (facility fee)	20% after deductible/ Not covered	40% after deductible/ Not covered
Diagnostic Labs and X-rays	$25/$45 (applies to 10-visit limit)	Labs $50/$70; X-rays $150/$170 (applies to 10-visit limit)
Special Diagnostic Procedures (CT, MRI, and PET scans)	20% after deductible/ Not covered	40% after deductible/ Not covered

All listed services, except preventive, are subject to the deductible.

HDHP					
Plan Options	**Plan 1**	**Plan 3**	**Plan 4**	**Plan 7**	**Plan 10**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$1,400	$1,500	$1,500	$2,000	$2,500
Deductible Accumulation	Aggregate				
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,800	$3,500	$3,500	$4,500	$5,000
Out-of-Pocket Maximum Accumulation	Embedded				
Office Visits–Primary Care	No charge	10%	20%	20%	30%
Office Visits–Specialty Care	No charge	10%	20%	20%	30%
Office Visits–Urgent Care	No charge	10%	20%	20%	30%
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	No charge	10%	20%	20%	30%
Emergency Care (copay waived if admitted)	No charge	10%	20%	20%	30%
Outpatient Surgery (facility fee)	No charge	10%	20%	20%	30%
Diagnostic Labs and X-rays	No charge	10%	20%	20%	30%
Special Diagnostic Procedures (CT, MRI, and PET scans)	No charge	10%	20%	20%	30%

HDHP						
Plan Options	**Plan 11**	**Plan 12**	**Plan 13**	**Plan 14**	**Plan 15**	**Plan 17**
Benefit/Feature	**Member pays**					
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,500	$2,500	$4,000	$5,000	$3,000	$1,500
Deductible Accumulation	Aggregate		Embedded		Aggregate	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$5,000	$6,000	$5,000	$6,000	$6,550	$3,500
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$20	20%	$20	$20	No charge	$20
Office Visits–Specialty Care	$30	20%	$30	$30	$30	$30
Office Visits–Urgent Care	$30	20%	$30	$30	$30	$30
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	$250	0%	$250	$250	$250	$500
Emergency Care (copay waived if admitted)	$200	20%	$200	$200	$150	$200
Outpatient Surgery (facility fee)	$100	20%	$100	$100	$125	$250
Diagnostic Labs and X-rays	$20	20%	$20	$20	$30	$20
Special Diagnostic Procedures (CT, MRI, and PET scans)	$150	20%	$150	$150	$250	$150

HDHP					
Plan Options	**Plan 18**	**MV Plan 1[1]**	**MV Plan 2[1]**	**MV Plan 3[1]**	**MV Plan 4[1]**
Benefit/Feature	**Member pays**				
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$2,000	$4,500	$4,500	$4,500	$5,500
Deductible Accumulation	Aggregate	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000	$6,250	$6,250	$6,350	$6,550
Out-of-Pocket Maximum Accumulation	Embedded				
Office Visits–Primary Care	$20	$50	40%	$20	30%
Office Visits–Specialty Care	$30	$50	40%	$30	30%
Office Visits–Urgent Care	Applicable office visit cost share will apply	$50	40%	$30	30%
Well-Child Care and Adult Preventive Services	No charge	No charge	No charge	No charge	No charge
Inpatient Hospital Care (facility fee)	$300/day up to 3 days	40%	40%	30%	30%
Emergency Care (copay waived if admitted)	$200	$250	40%	30%	30%
Outpatient Surgery (facility fee)	$200	40%	40%	30%	30%
Diagnostic Labs and X-rays	$20	40%	40%	30%	30%
Special Diagnostic Procedures (CT, MRI, and PET scans)	$150	40%	40%	30%	30%

[1]MV = Minimum Value

ADDED CHOICE

Plan Options	Plan 1		Plan 2	
Benefit/Feature	Member pays			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	$500	Not applicable	$500
Deductible Accumulation	Not applicable	Embedded	Not applicable	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$5,000	$2,250	$5,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$20	20% after deductible	$20	30% after deductible
Office Visits–Specialty Care	$40	20% after deductible	$40	30% after deductible
Office Visits–Urgent Care	$40	20% after deductible	$40	30% after deductible
Well-Child Care and Adult Preventive Services	No charge	20% after deductible	No charge	30% after deductible
Inpatient Hospital Care (facility fee)	$300	20% after deductible	$300	30% after deductible
Emergency Care (copay waived if admitted)	$100	Covered in-network	$100	Covered in-network
Outpatient Surgery (facility fee)	$100	20% after deductible	$100	30% after deductible
Diagnostic Labs and X-rays	No charge	20% after deductible	No charge	30% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	20% after deductible	$100	30% after deductible

ADDED CHOICE

Plan Options	Plan 3		Plan 4	
Benefit/Feature	Member pays			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	$1,500	Not applicable	$1,500
Deductible Accumulation	Not applicable	Embedded	Not applicable	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$5,000	$2,250	$5,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$25	20% after deductible	$25	30% after deductible
Office Visits–Specialty Care	$50	20% after deductible	$50	30% after deductible
Office Visits–Urgent Care	$50	$75	$50	$75
Well-Child Care and Adult Preventive Services	No charge	20% after deductible	No charge	30% after deductible
Inpatient Hospital Care (facility fee)	$400	20% after deductible	$400	30% after deductible
Emergency Care (copay waived if admitted)	$100	Covered in-network	$100	Covered in-network
Outpatient Surgery (facility fee)	$100	20% after deductible	$100	30% after deductible
Diagnostic Labs and X-rays	No charge	20% after deductible	No charge	30% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	20% after deductible	$100	30% after deductible

ADDED CHOICE

Plan Options	Plan 5		Plan 6	
Benefit/Feature	Member pays			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	$2,500	Not applicable	$2,500
Deductible Accumulation	Not applicable	Embedded	Not applicable	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000	$6,000	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$30	20% after deductible	$30	30% after deductible
Office Visits–Specialty Care	$40	20% after deductible	$40	30% after deductible
Office Visits–Urgent Care	$40	$65	$40	$65
Well-Child Care and Adult Preventive Services	No charge	20% after deductible	No charge	30% after deductible
Inpatient Hospital Care (facility fee)	$500	20% after deductible	$500	30% after deductible
Emergency Care (copay waived if admitted)	$100	Covered in-network	$100	Covered in-network
Outpatient Surgery (facility fee)	$100	20% after deductible	$100	30% after deductible
Diagnostic Labs and X-rays	No charge	20% after deductible	No charge	30% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	20% after deductible	$100	30% after deductible

FLEXIBLE CHOICE						
Plan Options	**Plan B**			**Plan C**		
Benefit/Feature	**Member pays**					
	Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	None	None	$600	None	$300	$600
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$3,000	$6,000	$2,250	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$15	$30 per visit	30% after deductible	$20	$35 per visit	30% after deductible
Office Visits–Specialty Care	$25	$40 per visit	30% after deductible	$30	$45 per visit	30% after deductible
Office Visits–Urgent Care	$25	$45 per visit	$65 per visit	$30	$50 per visit	$70 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	No charge	10%	30% after deductible	$100	10% after deductible	30% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$50	10%	30% after deductible	$75	10% after deductible	30% after deductible
Diagnostic Labs and X-rays	No charge	10%	30% after deductible	No charge	10% after deductible	30% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	10%	30% after deductible	$100	10% after deductible	30% after deductible

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[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

FLEXIBLE CHOICE

Plan Options	Plan D			Plan E		
Benefit/Feature	Member pays					
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	None	$500	$1,000	None	$1,000	$2,000
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$3,000	$6,000	$2,250	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$30	$45 per visit	30% after deductible	$30	$45 per visit	30% after deductible
Office Visits–Specialty Care	$40	$55 per visit	30% after deductible	$40	$55 per visit	30% after deductible
Office Visits–Urgent Care	$40	$55 per visit	$75 per visit	$40	$55 per visit	$75 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	$100	10% after deductible	30% after deductible	$250	10% after deductible	30% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$75	10% after deductible	30% after deductible	$100	10% after deductible	30% after deductible
Diagnostic Labs and X-rays	No charge	10% after deductible	30% after deductible	No charge	10% after deductible	30% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	10% after deductible	30% after deductible	$100	10% after deductible	30% after deductible

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[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

FLEXIBLE CHOICE

Plan Options	Plan F			Plan G		
Benefit/Feature	Member pays					
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	None	$1,500	$3,000	None	$300	$600
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$3,000	$6,000	$2,250	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$30	$45 per visit	30% after deductible	$20	$35 per visit	40% after deductible
Office Visits–Specialty Care	$40	$55 per visit	30% after deductible	$30	$45 per visit	40% after deductible
Office Visits–Urgent Care	$40	$55 per visit	$75 per visit	$30	$50 per visit	$70 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	$250	10% after deductible	30% after deductible	$100	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$100	10% after deductible	30% after deductible	$75	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	No charge	10% after deductible	30% after deductible	No charge	20% after deductible	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	10% after deductible	30% after deductible	$100	20% after deductible	40% after deductible

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[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

FLEXIBLE CHOICE

Plan Options	Plan H			Plan I		
Benefit/Feature	Member pays					
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	None	$500	$1,000	None	$1,000	$2,000
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$3,000	$6,000	$2,250	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$30	$45 per visit	40% after deductible	$30	$45 per visit	40% after deductible
Office Visits–Specialty Care	$40	$55 per visit	40% after deductible	$40	$55 per visit	40% after deductible
Office Visits–Urgent Care	$40	$55 per visit	$75 per visit	$40	$55 per visit	$75 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	$100	20% after deductible	40% after deductible	$250	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$75	20% after deductible	40% after deductible	$100	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	No charge	20% after deductible	40% after deductible	No charge	20% after deductible	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	20% after deductible	40% after deductible	$100	20% after deductible	40% after deductible

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[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

FLEXIBLE CHOICE						
Plan Options	**Plan J**			**Plan N**		
Benefit/Feature	**Member pays**					
	Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	None	$1,500	$3,000	None	$1,500	$3,000
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$3,000	$6,000	$2,250	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$30	$45 per visit	40% after deductible	$30	$45 per visit	50% after deductible
Office Visits–Specialty Care	$40	$55 per visit	40% after deductible	$40	$55 per visit	50% after deductible
Office Visits–Urgent Care	$40	$55 per visit	$75 per visit	$40	$55 per visit	$75 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	50% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	$250	20% after deductible	40% after deductible	$250	30% after deductible	50% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$100	20% after deductible	40% after deductible	$100	30% after deductible	50% after deductible
Diagnostic Labs and X-rays	No charge	20% after deductible	40% after deductible	No charge	30% after deductible	50% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	20% after deductible	40% after deductible	$100	30% after deductible	50% after deductible

This table is a limited summary of benefits (and applicable member cost shares)–Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), underwrites the In-Network HMO Tier (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3). Not all services and procedures are covered by your KFHP-MAS benefits contract or the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KFHP-MAS *Evidence of Coverage (EOC)* for Option 1 and the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)* for Options 2 and 3. In Option 3, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

FLEXIBLE CHOICE						
Plan Options	**F1A**			**F1B**		
Benefit/Feature	**Member pays**					
	Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	Not applicable	$3,000	$5,000	Not applicable	$5,000	$6,000
Deductible Accumulation	Not applicable	Embedded	Embedded	Not applicable	Embedded	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,250	$6,000	$8,000	$2,250	$6,000	$12,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$30	$45 per visit	30% after deductible	$30	$45 per visit	50% after deductible
Office Visits–Specialty Care	$40	$55 per visit	30% after deductible	$40	$55 per visit	50% after deductible
Office Visits–Urgent Care	$40	$55 per visit	$75 per visit	$40	$55 per visit	$75 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	30% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	50% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	$100	$250 after deductible	30% after deductible	$250	$200 after deductible	50% after deductible
Emergency Care (copay waived if admitted)	$100	Covered under Option 1	Covered under Option 1	$100	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	$75	$100 after deductible	30% after deductible	$100	$150 after deductible	50% after deductible
Diagnostic Labs and X-rays	No charge	$20 after deductible	30% after deductible	No charge	$20 after deductible	50% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$100	$200 after deductible	30% after deductible	$100	$200 after deductible	50% after deductible

This table is a limited summary of benefits (and applicable member cost shares)–Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), underwrites the In-Network HMO Tier (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3). Not all services and procedures are covered by your KFHP-MAS benefits contract or the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KFHP-MAS *Evidence of Coverage (EOC)* for Option 1 and the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)* for Options 2 and 3. In Option 3, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points

DEDUCTIBLE FLEXIBLE CHOICE						
Plan Options	**Plan Q**			**Plan R**		
Benefit/Feature	**Member pays**					
	Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$1,000	$2,000	$4,000	$250	$500	$2,000
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000	$3,850	$8,000	$2,000	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$20 per visit	$30 per visit	40% after deductible	$15 per visit	$25 per visit	40% after deductible
Office Visits–Specialty Care	$30 per visit	$40 per visit	40% after deductible	$25 per visit	$35 per visit	40% after deductible
Office Visits–Urgent Care	$30 per visit	$40 per visit	$60 per visit	$25 per visit	$35 per visit	$55 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$200 after deductible	Covered under Option 1	Covered under Option 1	$150 after deductible	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	$20 per visit	$30 per visit	40% after deductible	$15 per visit	$25 per visit	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible

This table is a limited summary of benefits (and applicable member cost shares)–Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), underwrites the In-Network HMO Tier (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3). Not all services and procedures are covered by your KFHP-MAS benefits contract or the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KFHP-MAS *Evidence of Coverage (EOC)* for Option 1 and the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)* for Options 2 and 3. In Option 3, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

DEDUCTIBLE FLEXIBLE CHOICE						
Plan Options	**Plan S**			**Plan T**		
Benefit/Feature	**Member pays**					
	Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$500	$1,000	$4,000	$2,000	$3,500	$6,000
Deductible Accumulation	Embedded					
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,000	$3,000	$8,000	$3,000	$4,000	$8,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	$20 per visit	$30 per visit	40% after deductible	$20 per visit	$30 per visit	40% after deductible
Office Visits–Specialty Care	$30 per visit	$40 per visit	40% after deductible	$30 per visit	$40 per visit	40% after deductible
Office Visits–Urgent Care	$30 per visit	$40 per visit	$60 per visit	$30 per visit	$40 per visit	$60 per visit
Well-Child Care and Adult Preventive Services	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$200 after deductible	Covered under Option 1	Covered under Option 1	10% after deductible	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	$20 per visit	$30 per visit	40% after deductible	$20 per visit	$30 per visit	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible

This table is a limited summary of benefits (and applicable member cost shares)–Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), underwrites the In-Network HMO Tier (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3). Not all services and procedures are covered by your KFHP-MAS benefits contract or the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KFHP-MAS *Evidence of Coverage (EOC)* for Option 1 and the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)* for Options 2 and 3. In Option 3, most services are subject to the deductible.

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HSA-QUALIFIED FLEXIBLE CHOICE

Plan Options	Plan U			Plan V		
Benefit/Feature	Member pays					
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Self-Only Deductible	$1,400	$2,000	$4,000	$1,500	$3,000	$4,000
Individual Deductible (per individual Family Member)	Not applicable	$2,800	$4,000	Not applicable	$3,000	$4,000
Family Deductible	$2,800	$4,000	$8,000	$3,000	$6,000	$8,000
Deductible Accumulation	Aggregate	Embedded	Embedded	Aggregate	Embedded	Embedded
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,800	$3,950	$8,000	$3,000	$3,650	$8,000
Out-of-Pocket Maximum Accumulation	Embedded					
Office Visits–Primary Care	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Office Visits–Specialty Care	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Office Visits–Urgent Care	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Well-Child Care and Adult Preventive Services	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible	No charge	No charge	40% (in DC and VA); 20% (in MD)[1] after deductible
Inpatient Hospital Care (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100 after deductible	Covered under Option 1	Covered under Option 1	$250 after deductible	Covered under Option 1	Covered under Option 1
Outpatient Surgery (facility fee)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible	20% after deductible	40% after deductible	10% after deductible	20% after deductible	40% after deductible

This table is a limited summary of benefits (and applicable member cost shares)–Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), underwrites the In-Network HMO Tier (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3). Not all services and procedures are covered by your KFHP-MAS benefits contract or the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KFHP-MAS *Evidence of Coverage (EOC)* for Option 1 and the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)* for Options 2 and 3. In Option 3, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

OUT-OF-AREA PPO				
Plan Options	**Plan 1**		**Plan 2**	
Benefit/Feature	**Member pays**			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$200	$400	$400	$800
Deductible Accumulation	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$2,000	$4,000	$4,000	$8,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$10 per visit	20% after deductible	$15 per visit	20% after deductible
Office Visits–Specialty Care	$20 per visit	20% after deductible	$25 per visit	20% after deductible
Office Visits–Urgent Care	$20 per visit	$40 per visit	$25 per visit	$45 per visit
Well-Child Care and Adult Preventive Services	No charge	20% after deductible	No charge	20% after deductible
Inpatient Hospital Care (facility fee)	No charge after deductible	20% after deductible	No charge after deductible	20% after deductible
Emergency Care (copay waived if admitted)	$100 per visit	$100 per visit	$100 per visit	$100 per visit
Outpatient Surgery (facility fee)	No charge after deductible	20% after deductible	No charge after deductible	20% after deductible
Diagnostic Labs and X-rays	No charge after deductible	20% after deductible	No charge after deductible	20% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$50 per test	20% after deductible	$50 per test	20% after deductible

Out-of-Area PPO plans are only available to employers who have membership out of area.

OUT-OF-AREA PPO				
Plan Options	**Plan 6**		**Plan 8**	
Benefit/Feature	**Member pays**			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$300	$600	$300	$600
Deductible Accumulation	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$3,000	$6,000	$3,000	$6,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$15 per visit	30% after deductible	$15 per visit	40% after deductible
Office Visits–Specialty Care	$25 per visit	30% after deductible	$25 per visit	40% after deductible
Office Visits–Urgent Care	$25 per visit	$45 per visit	$25 per visit	$45 per visit
Well-Child Care and Adult Preventive Services	No charge	30% after deductible (in DC and VA); 20% after deductible (in MD)[1]	No charge	40% after deductible (in DC and VA); 20% after deductible (in MD)[1]
Inpatient Hospital Care (facility fee)	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100 per visit	$100 per visit	$100 per visit	$100 per visit
Outpatient Surgery (facility fee)	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	$50 per test	30% after deductible	$50 per test	40% after deductible

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[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

OUT-OF-AREA PPO				
Plan Options	**Plan 9**		**Plan 10**	
Benefit/Feature	**Member pays**			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$500	$1,000	$500	$1,000
Deductible Accumulation	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000	$8,000	$4,000	$8,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$20 per visit	30% after deductible	$20 per visit	40% after deductible
Office Visits–Specialty Care	$30 per visit	30% after deductible	$30 per visit	40% after deductible
Office Visits–Urgent Care	$30 per visit	$50 per visit	$30 per visit	$50 per visit
Well-Child Care and Adult Preventive Services	No charge	30% after deductible (in DC and VA); 20% after deductible (in MD)[1]	No charge	40% after deductible (in DC and VA); 20% after deductible (in MD)[1]
Inpatient Hospital Care (facility fee)	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100 per visit	$100 per visit	$100 per visit	$100 per visit
Outpatient Surgery (facility fee)	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	$20 per visit	30% after deductible	$20 per visit	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	10% after deductible	30% after deductible	20% after deductible	40% after deductible

This table is a limited summary of benefits (and applicable member cost shares) underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP). KPIC underwrites the In-Network PPO Tier (Option 1) and Out-of-Network Tier (Option 2). Not all services and procedures are covered under the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KPIC *Group Policy* and *Certificate of Insurance (COI).* For Out-of-Network benefits, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

OUT-OF-AREA PPO				
Plan Options	**Plan 11**		**Plan 12**	
Benefit/Feature	**Member pays**			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$1,000	$2,000	$1,500	$3,000
Deductible Accumulation	Embedded			
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$4,000	$8,000	$5,000	$10,000
Out-of-Pocket Maximum Accumulation	Embedded			
Office Visits–Primary Care	$30 per visit	40% after deductible	$30 per visit	40% after deductible
Office Visits–Specialty Care	$40 per visit	40% after deductible	$40 per visit	40% after deductible
Office Visits–Urgent Care	$40 per visit	$60 per visit	$40 per visit	$60 per visit
Well-Child Care and Adult Preventive Services	No charge	40% after deductible (in DC and VA); 20% after deductible (in MD)[1]	No charge	40% after deductible (in DC and VA); 20% after deductible (in MD)[1]
Inpatient Hospital Care (facility fee)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Care (copay waived if admitted)	$100 per visit	$100 per visit	$100 per visit	$100 per visit
Outpatient Surgery (facility fee)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic Labs and X-rays	$30 per visit	40% after deductible	$40 per visit	40% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	20% after deductible	40% after deductible	20% after deductible	40% after deductible

This table is a limited summary of benefits (and applicable member cost shares) underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP). KPIC underwrites the In-Network PPO Tier (Option 1) and Out-of-Network Tier (Option 2). Not all services and procedures are covered under the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KPIC *Group Policy* and *Certificate of Insurance (COI).* For Out-of-Network benefits, most services are subject to the deductible.

[1]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

OUT-OF-AREA PPO		
Plan Options	**MV Plan 1[1]**	
Benefit/Feature	**Member pays**	
	In-Network	Out-of-Network
Individual Deductible (per plan year)–family deductible is twice the stated individual amount	$4,000	$6,000
Deductible Accumulation	Embedded	
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount	$7,000	$10,000
Out-of-Pocket Maximum Accumulation	Embedded	
Office Visits–Primary Care	$50 per visit	50% after deductible
Office Visits–Specialty Care	$60 per visit	50% after deductible
Office Visits–Urgent Care	$60 per visit	$80 per visit
Well-Child Care and Adult Preventive Services	No charge	50% after deductible (in DC and VA); 20% after deductible (in MD)[2]
Inpatient Hospital Care (facility fee)	30% after deductible	50% after deductible
Emergency Care (copay waived if admitted)	$100 per visit	$100 per visit
Outpatient Surgery (facility fee)	30% after deductible	50% after deductible
Diagnostic Labs and X-rays	30% after deductible	50% after deductible
Special Diagnostic Procedures (CT, MRI, and PET scans)	30% after deductible	50% after deductible

This table is a limited summary of benefits (and applicable member cost shares) underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP). KPIC underwrites the In-Network PPO Tier (Option 1) and Out-of-Network Tier (Option 2). Not all services and procedures are covered under the KPIC *Group Policy*. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are standard, "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. For details about the terms of coverage, including exclusions and limitations, please review the applicable KPIC *Group Policy* and *Certificate of Insurance (COI)*. For Out-of-Network benefits, most services are subject to the deductible.

[1]MV = Minimum Value
[2]For Maryland plans, the difference between the coinsurance percentage for Option 3 (Non-Participating Providers) and Option 2 (Participating Providers) will not be greater than 20 percentage points.

Compare plans

Plan							
Self-Only Deductible							
Individual Deductible (per individual Family Member)							
Family Deductible							
Individual Deductible (per plan year)–family deductible is twice the stated individual amount							
Deductible Accumulation							
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount							
Out-of-Pocket Maximum Accumulation							
Office Visits–Primary Care							
Office Visits–Specialty Care							
Office Visits–Urgent Care							
Well-Child Care and Adult Preventive Services							
Inpatient Hospital Care (facility fee)							
Emergency Care (copay waived if admitted)							
Outpatient Surgery (facility fee)							
Diagnostic Labs and X-rays							
Special Diagnostic Procedures (CT, MRI, and PET scans)							

Compare plans

Plan							
Self-Only Deductible							
Individual Deductible (per individual Family Member)							
Family Deductible							
Individual Deductible (per plan year)–family deductible is twice the stated individual amount							
Deductible Accumulation							
Individual Out-of-Pocket Maximum (per plan year)–family out-of-pocket maximum is twice the stated individual amount							
Out-of-Pocket Maximum Accumulation							
Office Visits–Primary Care							
Office Visits–Specialty Care							
Office Visits–Urgent Care							
Well-Child Care and Adult Preventive Services							
Inpatient Hospital Care (facility fee)							
Emergency Care (copay waived if admitted)							
Outpatient Surgery (facility fee)							
Diagnostic Labs and X-rays							
Special Diagnostic Procedures (CT, MRI, and PET scans)							

Start over

DEFINITIONS

Embedded deductible

If you have coverage for yourself plus one or more family members, each person has an individual deductible and there is a separate family deductible. When one family member meets his or her deductible before the family deductible is met, that family member pays only the applicable copays or coinsurance for covered services for the rest of the plan year, or until the out-of-pocket maximum is met (see definitions for out-of-pocket maximum below). Amounts paid toward individual deductibles are also applied toward the family deductible. The family deductible can be met by two or more family members. Once the family deductible is met, you begin paying only the applicable copays or coinsurance for everyone who is covered under your plan, no matter if each family member's individual deductible has not been met.

Example: Sarah's family has an embedded deductible. Each family member's individual deductible amount is $4,500, and their family deductible amount is $9,000. Sarah has a medical procedure and she pays an allowable charge of $2,000. This amount is applied toward her individual deductible and the family deductible. Later that year, her son, John, has an inpatient hospital stay that cost $5,500. The family pays $4,500 to meet John's individual deductible. The remaining $1,000 is subject to a 40% coinsurance for inpatient hospital services, according to the family's plan, so Sarah's family also pays for the $400 coinsurance charge while the health plan pays $600.

Now that John has met his individual deductible, he will only be responsible for paying the applicable copays and coinsurance for covered services for the rest of the plan year. Meanwhile, the family has paid $6,500 toward their family deductible of $9,000, so everyone else will continue paying the allowable charges for covered services until the individual or family deductible is met. Once the family deductible is met, the whole family will only be responsible for paying the applicable copays or coinsurance for covered services for the rest of the plan year, or until the out-of-pocket maximum is met (see definitions for out-of-pocket maximum below).

Embedded out-of-pocket maximum

An out-of-pocket maximum (OOPM) is a limit on health care expenses you and your family pay in a plan year.

If you have coverage for yourself plus one or more family members, each person has an individual OOPM and there is a separate family OOPM. When one family member reaches his or her OOPM, the health plan will pay for that individual's covered health care expenses for the rest of the plan year. Amounts paid toward individual OOPMs, such as deductible, copay, and coinsurance amounts, are also applied toward the family OOPM. The family OOPM can be met by two or more family members. Once the family OOPM is met, your health plan will pay for covered health care expenses for the rest of the plan year, even for those family members who have not met their individual OOPM.

Example: Sarah's family has an embedded OOPM. Each family member's individual OOPM amount is $3,000, and their family OOPM amount is $6,000. Sarah has a medical procedure and she pays $1,500 in allowable charges. This amount is applied toward her individual OOPM and the family OOPM. Later that year, her son, John, has several covered medical procedures totaling $4,000 of allowable charges. The family pays $3,000 and meets John's OOPM. The remaining $1,000 is paid for by the health plan.

Now that John has met his individual OOPM, he will pay nothing for covered services for the rest of the plan year. Meanwhile, the family has paid $4,500 toward their family OOPM of $6,000, so everyone else will continue paying for covered health care expenses until their individual or family OOPM is met. Once the family OOPM is met, the whole family will pay nothing for covered services for the rest of the plan year.

Aggregate deductible

If you have coverage for yourself plus one or more family members, the whole family has one aggregate deductible for the plan year; there is no individual member deductible in family plans. When one or more family members have paid enough in applicable health care expenses to meet the family's deductible, the health plan will begin to pay its share of the charges for the rest of the plan year, or until the out-of-pocket maximum is met (see definitions for out-of-pocket maximum below).

Example: Sarah's family has an aggregate deductible of $2,800 and 10% plan coinsurance after her deductible for all covered services. Sarah has a medical procedure and she pays an allowable charge of $1,800, which is applied to the family deductible. Later that year, her son, John, has an inpatient hospital stay that cost $1,500. The family pays $1,000 to meet their plan year deductible of $2,800. The remaining $500 is subject to a 10% coinsurance for inpatient hospital services, according to the family's plan, so Sarah's family also pays for the $50 coinsurance charge while the health plan pays $450. Now that the family deductible has been met, everyone in the family will pay only the applicable copays and coinsurance for covered services for the rest of the plan year, until the out-of-pocket maximum is met (see definitions for out-of-pocket maximum).

Aggregate out-of-pocket maximum

An out-of-pocket maximum (OOPM) is a limit on health care expenses you and your family pay in a plan year.

If you have coverage for yourself plus one or more family members, the whole family has one OOPM for the plan year. That means all covered family members' applicable health care expenses, such as deductible, copay, and coinsurance amounts, accumulate toward one family OOPM. There is no individual OOPM for each family member. Once the family OOPM is met by one or more family members, your health plan will pay for covered health care expenses for the rest of the plan year, even for those family members who did not contribute to the family OOPM.

Example: Sarah's family has an aggregate OOPM of $5,000. Sarah has a medical procedure and she pays $2,500 in allowable charges, which is applied toward the family OOPM. Later that year, her son, John, has an inpatient hospital stay that costs $3,000 of allowable charges. The family pays $2,500 and meets their plan year OOPM. The remaining $500 is paid for by the health plan. Now that the family OOPM has been met, everyone in the family will pay nothing for covered services for the rest of the plan year.

Flexible Choice plans—provider networks

Flexible Choice allows members to receive care from:

Option 1: Permanente physicians in the Mid-Atlantic Permanente Medical Group, P.C. (HMO).

Option 2: Providers in an extensive Participating Provider Organization (PPO) using PHCS™ and MultiPlan™ networks for KPIC.

Option 3: Any other licensed, non-contracted provider not in Options 1 or 2.

Kaiser Permanente Signature℠ provider network

With the Kaiser Permanente Signature provider network, members receive quality care provided by our physicians—a network of physicians who practice exclusively in our medical centers conveniently located throughout the covered Maryland, Virginia, and Washington, DC, service areas. You can choose a doctor at any time, for any reason, ensuring that your physician meets your needs. Our medical centers offer a range of services in one location, including primary care, lab, X-ray, and pharmacy. For inpatient services, members have convenient access to contracted hospitals located throughout the service area. When members receive care, tests, and screenings in our medical centers, they can use My Health Manager on **kp.org** to email their doctor's office, check most lab results, schedule and cancel appointments, order prescription refills for mail delivery or pickup, and much more.

Video visits[1] are available with a Permanente emergency medicine physician who is connected to a member's personal doctor and can access a member's medical history. Members can visit **kp.org** or use our mobile app to schedule a video visit. Members can also call the advice nurse anytime for a video appointment.

Kaiser Permanente Select℠ provider network

Building on our Signature physician network, Select adds access to contracted community physicians in private practice. Members may choose a Permanente physician in the Mid-Atlantic Permanente Medical Group, P.C., or a community physician and also have access to contracted hospitals located throughout the service area.

Preventive services

Kaiser Permanente covers preventive care services at no cost to you. These preventive services include:

- Blood pressure screening for all adults
- Cholesterol screening
- Colorectal cancer screening for adults over 50
- Type 2 diabetes screening for adults with high blood pressure
- Mammograms every 1 to 2 years for women over 40
- Cervical cancer screening for sexually active women
- Osteoporosis screening for women over 60, depending on risk factors
- Immunizations for children from birth to 18 years
- Obesity screening and counseling for children

For a comprehensive list of preventive services, visit **account.kp.org/broker-employer/resources/broker** and click on resource library.

[1] If you travel out of state, phone appointments and video visits may not be available due to state laws that may prevent doctors and health care providers from providing care across state lines. Laws differ by state.

DISTRICT OF COLUMBIA ASSOCIATED EXCLUSIONS AND LIMITATIONS[1]

Health plan (HMO, DHMO, and HDHP plans)

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services (HDHP only).

2. **Out-of-Pocket Maximum:**

   The following Services do not apply toward your Out-of-Pocket Maximum:

   - Adult eyeglass lenses and frames and contact lenses that are available with a discount only
   - Adult dental Services, if included by Rider attached to this plan
   - Adult routine eye exams (HMO and DHMO only)
   - In vitro fertilization (HMO and DHMO only)
   - Inpatient and outpatient infertility Services and drugs

3. **Emergency Services Limitations:**

   - **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit or hospital care you receive after transfer would have been possible.
   - **Continuing or Follow-up Treatment:** We do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
   - **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital, and your emergency room visit copayment will not be waived.

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring a chronic disease
   - Follow-up Services after you have been diagnosed with a disease
   - Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards
   - Services provided when you show signs or symptoms of a specific disease or disease process

[1]For applicable exclusions and limitations, please review the applicable *Evidence of Coverage (EOC).*

- Non-routine gynecological visits
- Treatment of a medical condition or problem identified during the course of a preventive screening exam

5. **Urgent Care Limitations:**

   We do not cover Services outside of our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside of our Service Area, such as dialysis for ESRD, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside of our Service Area because of an extreme personal emergency.

6. **Urgent Care Exclusions:**

   Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

KPIC (Flexible Choice [Options 2 and 3 only] and Out-of-Area PPO Plans)[1]

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services in Option 2 and visits subject to a per-visit copay.

2. **Out-of-Area:**

   Prudent layperson standard applies to Emergency Services, as does the general exclusions and limitations applicable to covered services generally.

3. **Emergency Services Limitations:**

   Flexible Choice—*Please refer to KFHP-MAS Option 1 coverage.*

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring a chronic disease
   - Follow-up Services after you have been diagnosed with a disease
   - Diagnostic testing for specific diseases
   - Services provided when you show signs or symptoms of a specific disease or disease process
   - Non-routine gynecological visits

5. **Urgent Care Limitations:**

   Limited to Medically Necessary covered services required to diagnose and treat an urgent, but non-life-threatening, covered sickness or injury. The standard limitations applicable to covered services generally apply to care received in an urgent care setting.

6. **Urgent Care Exclusions:**

   The standard exclusions applicable to covered services generally apply to care received in an urgent care setting.

[1]For applicable exclusions and limitations, please review the applicable *Certificate of Insurance (COI).*

MARYLAND ASSOCIATED EXCLUSIONS AND LIMITATIONS[1]

Health plan (HMO, DHMO, and HDHP plans)

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services (HDHP only).

2. **Out-of-Pocket Maximum:**

   The following Services do not apply toward your Out-of-Pocket Maximum:

   - Adult eyeglass lenses and frames and contact lenses that are available with a discount only
   - Adult dental Services, if included by Rider attached to this plan
   - Adult routine eye exams (HMO and DHMO only)

3. **Emergency Services Limitations:**

   - **Notification:** If you are admitted to a non-Plan hospital, you, or someone on your behalf, should notify us as soon as possible, but not later than forty-eight (48) hours or the end of the first (1st) business day, whichever is later, after the hospital admission unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the hospital care you receive after transfer would have been possible. If possible, we urge you or your authorized representative to notify us of any emergency room visits to assist you in coordinating any necessary follow-up care.
   - **Continuing or Follow-up Treatment:** Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Permanente Region or Group Health Cooperative service area.
   - **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital, and your emergency room visit copayment will not be waived.

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring a chronic disease
   - Follow-up Services after you have been diagnosed with a disease
   - Services provided when you show signs or symptoms of a specific disease or disease process
   - Non-routine gynecological visits

[1]For applicable exclusions and limitations, please review the applicable *Evidence of Coverage (EOC).*

5. **Urgent Care Limitations:**

   We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for ESRD, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

6. **Urgent Care Exclusions:**

   Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

KPIC (Flexible Choice [Options 2 and 3 only] and Out-of-Area PPO Plans)[1]

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services in Option 2 and visits subject to the per-visit copay.

2. **Out-of-Area:**

   Prudent layperson standard applies to Emergency Services, as do the general exclusions and limitations applicable to covered services generally.

3. **Emergency Services Limitations:**

   Flexible Choice—*Please refer to KFHP-MAS's Option 1 coverage*.

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring a chronic disease
   - Follow-up Services after you have been diagnosed with a disease
   - Diagnostic testing for specific diseases
   - Services provided when you show signs or symptoms of a specific disease or disease process
   - Non-routine gynecological visits

5. **Urgent Care Limitations:**

   Limited to Medically Necessary covered services required to diagnose and treat an urgent, but non-life-threatening, covered sickness or injury. The standard limitations applicable to covered services generally apply to care received in an urgent care setting.

6. **Urgent Care Exclusions:**

   The standard exclusions applicable to covered services generally apply to care received in an urgent care setting.

[1]For applicable exclusions and limitations, please review the applicable *Certificate of Insurance (COI).*

VIRGINIA ASSOCIATED EXCLUSIONS AND LIMITATIONS[1]

Health plan (HMO, DHMO, and HDHP plans)

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services (HDHP only).

2. **Out-of-Pocket Maximum:**

   The following Services do not apply toward your Out-of-Pocket Maximum:

   - Adult eyeglass lenses and frames and contact lenses that are available with a discount only
   - Adult dental Services, if included by Rider attached to this plan
   - Adult routine eye exams (HMO and DHMO only)
   - In vitro fertilization (HMO and DHMO only)
   - Inpatient and outpatient infertility Services and drugs

3. **Emergency Services Limitations:**

   - **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours after the emergency room visit or hospital admission, or the next business day, whichever is later, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been stabilized, all continuing and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.
   - **Continuing or Follow-up Treatment:** Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside of our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
   - **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit copayment, if applicable, will not be waived.

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring chronic disease
   - Follow-up Services after you have been diagnosed with a disease

[1]For applicable exclusions and limitations, please review the applicable *Evidence of Coverage (EOC).*

- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards
- Services provided when you show signs or symptoms of a specific disease or disease process
- Non-routine gynecological visits

5. **Urgent Care Limitations:**

   We do not cover Services outside of our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside of our Service Area, such as dialysis for ESRD, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside of our Service Area because of an extreme personal emergency.

6. **Urgent Care Exclusions:**

   Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

KPIC (Flexible Choice [Options 2 and 3 only] and Out-of-Area PPO Plans)[1]

1. **Deductible:**

   The Deductible applies to all covered services except Preventive Health Care Services in Option 2 and visits subject to the per-visit copay.

2. **Out-of-Area:**

   Prudent layperson standard applies to emergency Services, as do the general exclusions and limitations applicable to covered services generally.

3. **Emergency Services Limitations:**

   Flexible Choice—*Please refer to KFHP-MAS's Option 1 coverage*.

4. **Preventive Health Services Limitation:**

   While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

   - Monitoring chronic disease
   - Follow-up Services after you have been diagnosed with a disease
   - Diagnostic testing for specific diseases
   - Services provided when you show signs or symptoms of a specific disease or disease process
   - Non-routine gynecological visits

[1]For applicable exclusions and limitations, please review the applicable *Certificate of Insurance (COI).*

5. **Urgent Care Limitations:**

   Limited to Medically Necessary covered services required to diagnose and treat an urgent, but non-life-threatening, covered sickness or injury. The standard limitations applicable to covered services generally apply to care received in an urgent care setting.

6. **Urgent Care Exclusions:**

   The standard exclusions applicable to covered services generally apply to care received in an urgent care setting.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), is not bound by the exclusions and limitations listed here; instead, the benefits, services, exclusions, and limitations that apply are listed in the *Group Agreement* and *Evidence of Coverage* provided in a separate document. Consult the *Group Agreement* and *Evidence of Coverage* to determine governing contractual provisions including detailed benefits, exclusions, and limitations related to the group benefit plan. The *Group Agreement* and *Evidence of Coverage* are the legally binding document between KFHP-MAS and groups. In the event of ambiguity, or a conflict between this summary and the *Group Agreement* and *Evidence of Coverage,* the *Group Agreement* and *Evidence of Coverage* shall control. Members enrolled with KFHP-MAS will also receive a copy of the *Evidence of Coverage.* In the event of ambiguity, or a conflict between this summary and the member's *Evidence of Coverage,* the *Evidence of Coverage* shall control.

Kaiser Permanente Insurance Company (KPIC) will be bound by the exclusions and limitations listed in the applicable *Group Policy,* which includes the *Certificate of Insurance.* Consult the actual *Group Policy* to determine the governing contractual provisions, including detailed benefits, exclusions, and limitations related to the group benefit plan. The *Group Policy* is a legally binding document between KPIC and the group. In the event of ambiguity or a conflict between this summary and the *Group Policy,* the *Group Policy* shall control. Members enrolled with KPIC will also receive a copy of the *Certificate of Insurance* and *Schedule of Coverage.* In the event of ambiguity, or a conflict between this summary and the member's *Certificate of Insurance* and *Schedule of Coverage,* the *Group Policy* shall control.

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.

In the event of dispute, the provisions of the approved English version of the form will control.

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 ተዘጋጅተዋል፡ 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. Ɖá **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** (TTY: **711**) تماس بگیرید.

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) સૂચના: 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**).

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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, koji' hódíílnih **1-800-777-7902** (TTY: **711**).

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- 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:
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If you need these services, call **1-800-777-7902** (TTY: **711**)

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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**).

Ɓăsɔ̀ɔ̀ 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 ɓɛ́ìn m̀ gbo kpáa. Ɖá **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**）。

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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.
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