Small Business Plan Summaries | WASHINGTON, DC | 2024

COVERAGE OPTIONS

Employees may choose from four plan categories (metal levels):

PLATINUM
- Highest monthly premium
- Zero/lowest deductible

GOLD
- Higher monthly premium
- Lower deductible

SILVER
- Moderate monthly premium
- Moderate deductible

BRONZE
- Lowest monthly premium
- Highest deductible

PORTFOLIO SNAPSHOT

Lower cost ← Price spectrum → Higher cost

	HSA-Qualified Consumer-Directed Health Plan	Virtual Forward/ Virtual Complete	HMO/ Deductible HMO	KP Plus/ Deductible Plus	Added Choice 2-Tier POS	Flexible Choice 3-Tier POS[1]
Product features	• Lowest cost plans at premium level • Option for tax-advantaged savings account • IRS-regulated minimum deductible • All benefits subject to deductible	• $0 virtual visits • Small number of in-person primary care visits each year at no or low cost • In-person preventive care at no charge • No referrals needed for in-person care	• Well-priced and quality health care with very predictable costs • Minimal costs subject to deductible • Broad range of deductibles and copays • Also available in the Select care system: more community providers than that for core Signature	• In-network: Identical to comprehensive Kaiser Permanente HMO • Coverage outside Kaiser Permanente for up to 10 outpatient visits a year (limits apply) • Up to 5 pharmacy fills a year at facilities outside Kaiser Permanente • Price advantage compared to Added Choice and Flexible Choice	• In-network: Identical to comprehensive Kaiser Permanente HMO • Out-of-network: any licensed provider in the US • No referrals needed to see a specialist in Tier 2 • Choice of provider each time care is sought • Competitive option that fits needs of all employees	• In-network Tier 1: Identical to comprehensive Kaiser Permanente HMO • In-network Tier 2: Curated national PPO network • Out-of-network: Any licensed provider in US • No referrals required for specialists in Tiers 2 and 3 • Offer side-by-side with other Kaiser Permanente plans to lower overall costs and still offer choice
May be a good fit for those who:	• Desire tax-advantaged long-term savings vehicle • Are willing to pay higher out-of-pocket costs at point of care • Are in a workforce with relatively low care needs • Are close to and/or contained within the Kaiser Permanente delivery footprint	• Seek the convenience of virtual-oriented care model • Need to limit upfront benefit costs • Desire a degree of pre-deductible primary care coverage • Are in savvy workforce with low in-person care needs	• Value quality and the convenience of fully integrated model • Seek to balance premium cost and comprehensive coverage • Are close to and/or contained within the Kaiser Permanente delivery footprint	• Want the option to keep current primary care provider and/or care relationships while transitioning to Kaiser Permanente • Are new to integrated care, trying out options • Have some care needs outside the Kaiser Permanente service area but not for full coverage (e.g., limited workforce travel)	• Have sustained care needs outside the Kaiser Permanente service area (e.g., college students) • Sole carrier groups • Have a strong preference for choice • Have experience with two-tier products • Have larger groups with most employees within and around the Kaiser Permanente footprint	• Have a broad range of employees with divergent needs • Have senior leaders who need choice and/or employment benefit • Are new to integrated care with strong choice preference • Have employees who travel often outside the Kaiser Permanente footprint • Have large and mid-size groups with employees both within and outside the Kaiser Permanente footprint
Relative price[2]	• 0.80x	• 0.80x – 0.90x	• 1.00x – 1.05x	• 1.04x	• 1.24x	• 1.36x

[1]Available in Maryland and Virginia only
[2]Compared to HMOs with similar benefits

TABLE OF CONTENTS

Washington, DC, health plans

PLATINUM PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Platinum 0/10/Vision**	**KP DC Platinum Plus[ie] 0/10/Vision**		**KP DC Platinum[ia] 500/10/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Individual plan annual deductible (subscriber only)	None	None	Not applicable	$500
Family plan annual deductible (individual/family)	None/None	None/None	Not applicable	$500/$1,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	$2,000/$2,400	$2,000/$2,400	Not applicable	$2,500
Family plan annual out-of-pocket maximum (individual/family)	$2,400/$4,800	$2,400/$4,800	Not applicable	$2,500/$5,000
Network[iii]	Signature or Select	Signature only	Not applicable	Signature or Select
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$10	$10	$30 (applies to 10-visit limit)	$10
Specialty care office visit	$30	$30	$50 (applies to 10-visit limit)	$30
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	X-ray $30/Lab $10	X-ray $30/Lab $10	X-ray $50/Lab $30 (applies to 10-visit limit)	X-ray $30/Lab $10
MRI/CT/PET	$100	$100	Not covered	$100 after deductible
Telehealth	No charge	No charge	$30 (applies to 10-visit limit)	No charge
Outpatient facility fee	$100	$100	Not covered	$150 after deductible
Mental health/chemical dependency outpatient	$10 individual therapy $5 group therapy	$10 individual therapy $5 group therapy	$30 individual therapy $15 group therapy (applies to 10-visit limit)	$10 individual therapy $5 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$150 per admission	$150 per admission	Not covered	$250 after deductible per admission

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Platinum 0/10/Vision**	**KP DC Platinum Plus[ie] 0/10/Vision**		**KP DC Platinum[ia] 500/10/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Prescription Drugs (30-day supply)				
Rx–deductible	None	None	Not applicable	None
Rx–generic drugs (Tier 1)	$5	$5	$25 (each fill/refill applies to the 5-prescription limit)	$5
Rx–preferred brand drugs (Tier 2)	$25	$25	$45 (each fill/refill applies to the 5-prescription limit)	$40
Rx–non-preferred brand drugs (Tier 3)	$50	$50	$70 (each fill/refill applies to the 5-prescription limit)	$60
Rx–specialty drugs (Tier 4)	50% up to $150	50% up to $150	60% up to $150 (each fill/refill applies to the 5-prescription limit)	50% up to $150
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	$30	$30	$30	$30
Emergency room	$150 (waived if admitted)	$150 (waived if admitted)	$150 (waived if admitted)	$250 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	$30	$30	$50 (applies to 10-visit limit)	$30
Pediatric Dental Services				
Periodic oral evaluation	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	$10	$10	Not covered	$10
Frames	No charge[2]	No charge[2]	Not covered	No charge[2]
Lenses	No charge[2]	No charge[2]	Not covered	No charge[2]
Contacts	No charge[3]	No charge[3]	Not covered	No charge[3]
Adult Vision Services				
Routine eye exam with optometrist	$10	$10	Not covered	$10
Frames	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Lenses	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Contacts	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]

For details about (ia), (ie), and (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

PLATINUM PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Platinum Added Choice 0/10/POS/Vision		KP DC Platinum Added Choice 500/10/POS/Vision		KP DC Standard Platinum 0/20/10%/Vision
	Kaiser Permanente Providers	**Out-of-Network Providers**	**Kaiser Permanente Providers**	**Out-of-Network Providers**	**Kaiser Permanente Providers**
Individual plan annual deductible (subscriber only)	None	$1,000	$500	$1,000	$0
Family plan annual deductible (individual/family)	None/None	$1,000/$2,000	$500/$1,000	$1,000/$2,000	$0/$0
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	80%/20%	100%/0%	80%/20%	90%/10%
Individual plan annual out-of-pocket maximum (subscriber only)	$2,400	$4,800	$2,500	$5,000	$2,000
Family plan annual out-of-pocket maximum (individual/family)	$2,400/$4,800	$4,800/$9,600	$2,500/$5,000	$5,000/$10,000	$2,000/$4,000
Network[iii]	Signature only	Not applicable	Signature only	Not applicable	Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit (copay waived for children under 5 years old)	$10	$30 after deductible	$10	$30 after deductible	$20 (not waived for children under age 5)
Specialty care office visit	$30	$50 after deductible	$30	$50 after deductible	$40
Preventive care/screening/immunization	No charge	20% after deductible	No charge	20% after deductible	No charge
X-ray and lab diagnostic services	X-ray $30/Lab $10	20% after deductible	X-ray $30/Lab $10	20% after deductible	X-ray $40/Lab $20
MRI/CT/PET	$100	20% after deductible	$100 after deductible	20% after deductible	$150
Telehealth	No charge	Applicable cost shares will apply based on type of provider	No charge	Applicable cost shares will apply based on type of provider	No charge
Outpatient facility fee	$100	20% after deductible	$150 after deductible	20% after deductible	$250
Mental health/chemical dependency outpatient	$10 individual therapy $5 group therapy	$30 individual therapy $15 group therapy after deductible	$10 individual therapy $5 group therapy	$30 individual therapy $15 group therapy after deductible	$20 individual therapy $10 group therapy
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	20% after deductible	No charge	20% after deductible	No charge
Inpatient Services					
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$150 per admission	20% after deductible	$250 per admission after deductible	20% after deductible	$250 per day up to 5 days per admission
Prescription Drugs (30-day supply)					
Rx–deductible	None	Medical deductible applies	None	Medical deductible applies	None
Rx–generic drugs (Tier 1)	$5	20% after deductible	$5	20% after deductible	$5
Rx–preferred brand drugs (Tier 2)	$25	20% after deductible	$40	20% after deductible	$15
Rx–non-preferred brand drugs (Tier 3)	$50	20% after deductible	$60	20% after deductible	$25
Rx–specialty drugs (Tier 4)	50% up to $150	50% up to $150 after deductible	50% up to $150	50% up to $150 after deductible	$100

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Platinum Added Choice 0/10/POS/Vision		KP DC Platinum Added Choice 500/10/POS/Vision		KP DC Standard Platinum 0/20/10%/Vision
	Kaiser Permanente Providers	**Out-of-Network Providers**	**Kaiser Permanente Providers**	**Out-of-Network Providers**	**Kaiser Permanente Providers**
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	$30	$50 after deductible	$30	$50 after deductible	$40
Emergency room	$150 (waived if admitted)	$150 (waived if admitted)	$250 after deductible (waived if admitted)	$250 after deductible (waived if admitted)	$150 (waived if admitted)
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	$30	$50 after deductible	$30	$50 after deductible	$20
Pediatric Dental Services					
Periodic oral evaluation	$0[1]	Not covered	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	Not covered	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	Not covered	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services					
Routine eye exam with optometrist	$10	$30 after deductible	$10	$30 after deductible	No charge
Frames	No charge[2]	20% after deductible	No charge[2]	20% after deductible	No charge[2]
Lenses	No charge[2]	20% after deductible	No charge[2]	20% after deductible	No charge[2]
Contacts	No charge[3]	20% after deductible	No charge[3]	20% after deductible	No charge[3]
Adult Vision Services					
Routine eye exam with optometrist	$10	$30 after deductible	$10	$30 after deductible	$20
Frames	$125 discount off retail price[4]	10% discount off retail price[4]	$125 discount off retail price[4]	10% discount off retail price	$90 discount off retail price[4]
Lenses	$125 discount off retail price[4]	10% discount off retail price[4]	$125 discount off retail price[4]	10% discount off retail price	$90 discount off retail price[4]
Contacts	$125 discount off retail price[4]	5% discount off retail price[4]	$125 discount off retail price[4]	5% discount off retail price	$25 discount off retail price[4]

For details about (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

GOLD PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Gold 0/20/Vision**	**KP DC Gold Plus[ie] 0/20/Vision**		**KP DC Gold[ia] 500/20/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Individual plan annual deductible (subscriber only)	$0	$0	Not applicable	$500
Family plan annual deductible (individual/family)	$0	$0	Not applicable	$500/$1,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	$8,250	$8,250	Not applicable	$6,750
Family plan annual out-of-pocket maximum (individual/family)	$8,250/$16,500	$8,250/$16,500	Not applicable	$6,750/$13,500
Network[iii]	Signature or Select	Signature only	Not applicable	Signature or Select
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$20	$20	$40 (applies to 10-visit limit)	$20
Specialty care office visit	$50	$50	$70 (applies to 10-visit limit)	$50
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	$50	$50	$70 (applies to 10-visit limit)	$50
MRI/CT/PET	$300	$300	Not covered	$350 after deductible
Telehealth	No charge	No charge	$40 (applies to 10-visit limit)	No charge
Outpatient facility fee	$200	$200	Not covered	$250 after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$40 individual therapy $20 group therapy (applies to 10-visit limit)	$20 individual therapy $10 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per admission	$500 per admission	Not covered	$500 per admission after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Gold 0/20/Vision**	**KP DC Gold Plus[ie] 0/20/Vision**		**KP DC Gold[ia] 500/20/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Prescription Drugs (30-day supply)				
Rx–deductible	None	None	Not applicable	None
Rx–generic drugs (Tier 1)	$10	$10	$30 (each fill/refill applies to the 5-prescription limit)	$10
Rx–preferred brand drugs (Tier 2)	$60	$60	$80 (each fill/refill applies to the 5-prescription limit)	$50
Rx–non-preferred brand drugs (Tier 3)	$100	$100	$120 (each fill/refill applies to the 5-prescription limit)	$100
Rx–specialty drugs (Tier 4)	50% up to $150	50% up to $150	60% up to $150 (each fill/refill applies to the 5-prescription limit)	50% up to $150
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	$50	$50	$50	$50
Emergency room	$250 (waived if admitted)	$250 (waived if admitted)	$250 (waived if admitted)	$300 (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	$50	$50	$70 (applies to 10-visit limit)	$50
Pediatric Dental Services				
Periodic oral evaluation	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	$20	$20	Not covered	$20
Frames	No charge[2]	No charge[2]	Not covered	No charge[2]
Lenses	No charge[2]	No charge[2]	Not covered	No charge[2]
Contacts	No charge[3]	No charge[3]	Not covered	No charge[3]
Adult Vision Services				
Routine eye exam with optometrist	$20	$20	Not covered	$20
Frames	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Lenses	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Contacts	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]

For details about (ia), (ie), and (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts–$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Gold 500/25/20%Vision**	**KP DC Gold[ia] 1,000/300 RxDed/ 20/Vision**	**KP DC Gold[ib] 1,500/300 RxDed/ 20/Vision**	**KP DC Gold Plus[ia][ie] 1,500/300 RxDed/20/Vision**	
				Kaiser Permanente Providers	**Out-of-Network Providers**
Individual plan annual deductible (subscriber only)	$500	$1,000	$1,500	$1,500	Not applicable
Family plan annual deductible (individual/family)	$500/$1,000	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000	Not applicable
Member coinsurance (plan pays/ member pays), except as otherwise indicated	80%/20%	100%/0%	100%/0%	100%/0%	Not applicable
Individual plan annual out-of-pocket maximum (subscriber only)	$5,800	$6,750	$7,100	$7,100	Not applicable
Family plan annual out-of-pocket maximum (individual/family)	$5,800/$11,600	$6,750/$13,500	$7,100/$14,200	$7,100/$14,200	Not applicable
Network[iii]	Signature	Signature or Select	Signature or Select	Signature only	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit (copay waived for children under 5 years old)	$25 (not waived for children under age 5)	$20	$20	$20	$40 (applies to 10-visit limit)
Specialty care office visit	$50	$50	$55	$55	$75 (applies to 10-visit limit)
Preventive care/screening/ immunization	No charge	No charge	No charge	No charge	No charge (applies to 10-visit limit)
X-ray and lab diagnostic services	X-ray $50/Lab $30	$50	$50	$50	$70 (applies to 10-visit limit)
MRI/CT/PET	$250	$350 after deductible	$300 after deductible	$300 after deductible	Not covered
Telehealth	No charge	No charge	No charge	No charge	$40 (applies to 10-visit limit)
Outpatient facility fee	$500	$250 after deductible	$250 after deductible	$250 after deductible	Not covered
Mental health/chemical dependency outpatient services	$25 Individual therapy $12 group therapy	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$40 individual therapy $20 group therapy (applies to 10-visit limit)
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	No charge	Not covered
Inpatient Services					
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$600 per day, up to 5 days per admission after deductible	$500 per admission after deductible	$500 per admission after deductible	$500 per admission after deductible	Not covered

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Gold 500/25/20%Vision**	**KP DC Gold[ia] 1,000/300 RxDed/ 20/Vision**	**KP DC Gold[ib] 1,500/300 RxDed/ 20/Vision**	**KP DC Gold Plus[ia][ie] 1,500/300 RxDed/20/Vision**	
				Kaiser Permanente Providers	**Out-of-Network Providers**
Prescription Drugs (30-day supply)					
Rx–deductible	None	$300	$300	$300	Not applicable
Rx–generic drugs (Tier 1)	$15	$10	$10	$10	$30 (each fill/refill applies to the 5-prescription limit)
Rx–preferred brand drugs (Tier 2)	$50	$60 after Rx deductible	$60 after Rx deductible	$60 after Rx deductible	$80 (each fill/refill applies to the 5-prescription limit)
Rx–non-preferred brand drugs (Tier 3)	$70	$100 after Rx deductible	$100 after Rx deductible	$100 after Rx deductible	$120 (each fill/refill applies to the 5-prescription limit)
Rx–specialty drugs (Tier 4)	$150	50% up to $150 after Rx deductible	50% up to $150 after Rx deductible	50% up to $150 after Rx deductible	60% up to $150 (each fill/refill applies to the 5-prescription limit)
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	$60	$50	$55	$55	$55
Emergency room	$300 (waived if admitted)	$400 after deductible (waived if admitted)	$350 after deductible (waived if admitted)	$350 after deductible (waived if admitted)	$350 after deductible (waived if admitted)
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	$30	$50	$50	$50	$70 (applies to 10-visit limit)
Pediatric Dental Services					
Periodic oral evaluation	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Prophylaxis (cleaning)	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Topical application of fluoride	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered
Pediatric Vision Services					
Routine eye exam with optometrist	No charge	$20	$20	$20	Not covered
Frames	No charge[2]	No charge[2]	No charge[2]	No charge[2]	Not covered
Lenses	No charge[2]	No charge[2]	No charge[2]	No charge[2]	Not covered
Contacts	No charge[3]	No charge[3]	No charge[3]	No charge[3]	Not covered
Adult Vision Services					
Routine eye exam with optometrist	$25	$20	$20	$20	Not covered
Frames	$90 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered
Lenses	$90 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered
Contacts	$25 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered

For details about (ia), (ib), (ie), and (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).
All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Gold[ic] 1,700/0%/HSA/Vision	KP DC Gold Added Choice[id] 1,000/300 RxDed/20/POS		KP DC Gold Virtual Complete 2,000
		In-Network	Out-of-Network	
Individual plan annual deductible (subscriber only)	$1,700	$1,000	$2,000	$2,000
Family plan annual deductible (individual/family)	Not applicable/$3,400 (family deductible only)	$1,000/$2,000	$2,000/$4,000	$4,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	80%/20%	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$5,000	$6,750	$13,500	$5,850
Family plan annual out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,750/$13,500	$13,500/$27,000	$5,850/$11,700
Network[iii]	Signature or Select	Signature only	Not applicable	Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	No charge after deductible	$20	$45 after deductible	$20 for the first three visits, then $20 after deductible
Specialty care office visit	No charge after deductible	$50	$55 after deductible	$50 after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible	No charge
X-ray and lab diagnostic services	No charge after deductible	$50	20% after deductible	X-ray 20% after deductible/ Lab $50
MRI/CT/PET	No charge after deductible	$350 after deductible	20% after deductible	20% after deductible
Telehealth	No charge after deductible	No charge	Applicable cost shares apply based on type of provider	No charge
Outpatient facility fee	$100 after deductible	$250 after deductible	20% after deductible	20% after deductible
Mental health/chemical dependency outpatient services	No charge after deductible	$20 individual therapy $10 group therapy	$45 individual therapy $30 group therapy (after deductible)	$20 for the first three visits, then $20 individual therapy after deductible $10 for the first three visits, then $10 group therapy after deductible
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	20% after deductible	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$100 after deductible	$500 per admission after deductible	20% after deductible	20% after deductible
Prescription Drugs (30-day supply)				
Rx–deductible	Medical deductible applies	$300	Medical deductible applies	Medical deductible applies
Rx–generic drugs (Tier 1)	$10 after deductible	$10	20% after deductible	$10
Rx–preferred brand drugs (Tier 2)	$45 after deductible	$60 after Rx deductible	20% after deductible	20% after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Gold[ic] 1,700/0%/HSA/Vision	KP DC Gold Added Choice[id] 1,000/300 RxDed/20/POS		KP DC Gold Virtual Complete 2,000
		In-Network	Out-of-Network	
Prescription Drugs (30-day supply) (Cont.)				
Rx–non-preferred brand drugs (Tier 3)	$75 after deductible	$100 after Rx deductible	20% after deductible	20% after deductible
Rx–specialty (Tier 4)	50% up to $150 after deductible	50% up to $150 after Rx deductible	50% up to $150 after deductible	50% up to $150 after deductible
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	No charge after deductible	$50	$55 after deductible	$50 after deductible
Emergency room	$200 after deductible (waived if admitted)	$400 after deductible (waived if admitted)	$400 after deductible (waived if admitted)	20% after deductible
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	No charge after deductible	$50	$55 after deductible	$50 after deductible
Pediatric Dental Services				
Periodic oral evaluation	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	No charge after deductible	$20	$45 after deductible	$20 for the first three visits, then $20 after deductible
Frames	No charge after deductible[2]	No charge[2]	20% after deductible[2]	No charge[2]
Lenses	No charge after deductible[2]	No charge[2]	20% after deductible[2]	No charge[2]
Contacts	No charge after deductible[3]	No charge[3]	20% after deductible[3]	No charge[3]
Adult Vision Services				
Routine eye exam with optometrist	No charge after deductible	$20	$45 after deductible	$20 for the first three visits, then $20 after deductible
Frames	Not covered	$125 discount off retail price[4]	10% discount off retail price	$125 discount off retail price
Lenses	Not covered	$125 discount off retail price[4]	10% discount off retail price	$125 discount off retail price
Contacts	Not covered	$125 discount off retail price[4]	5% discount off retail price	$125 discount off retail price

For details about (ic), (id), and (iii), see the Definitions section on page 23.

[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.

[2]One pair per year from a selected group of frames.

[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

SILVER PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Silver[ia] 1,750/250 RxDed/40/Vision**	**KP DC Silver Plus[ie] 1,750/250 RxDed/40/Vision**		**KP DC Silver[ia] 2,500/250 RxDed/40/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Individual plan annual deductible (subscriber only)	$1,750	$1,750	Not applicable	$2,500
Family plan annual deductible (individual/family)	$1,750/$3,500	$1,750/$3,500	Not applicable	$2,500/$5,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	$9,000	$9,000	Not applicable	$9,100
Family plan annual out-of-pocket maximum (individual/family)	$9,000/$18,000	$9,000/$18,000	Not applicable	$9,100/$18,200
Network[iii]	Signature only	Signature only	Not applicable	Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$40	$40	$60 (applies to 10-visit limit)	$40
Specialty care office visit	$50 after deductible	$50 after deductible	$100 (applies to 10-visit limit)	$80
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	X-ray $80/Lab $40 (after deductible)	X-ray $80/Lab $40 (after deductible)	X-ray $100/Lab $60 (applies to 10-visit limit)	X-ray $80/Lab $40
MRI/CT/PET	$400 after deductible	$400 after deductible	Not covered	$400 after deductible
Telehealth	No charge	No charge	$60 (applies to 10-visit limit)	No charge
Outpatient facility fee	$350 after deductible	$350 after deductible	Not covered	$350 after deductible
Mental health/chemical dependency outpatient services	$40 individual therapy $20 group therapy	$40 individual therapy $20 group therapy	$60 individual therapy $30 group therapy (applies to 10-visit limit)	$40 individual therapy $20 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per day up to 3 days per admission after deductible	$500 per day up to 3 days per admission after deductible	Not covered	$500 per day up to 3 days per admission after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Silver[ia] 1,750/250 RxDed/40/Vision**	**KP DC Silver Plus[ie] 1,750/250 RxDed/40/Vision**		**KP DC Silver[ia] 2,500/250 RxDed/40/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Prescription Drugs (30-day supply)				
Rx–deductible	$250	$250	Not applicable	$250
Rx–generic drugs (Tier 1)	$20	$20	$40 (each fill/refill applies to the 5-prescription limit)	$20
Rx–preferred brand drugs (Tier 2)	$50 after Rx deductible	$50 after Rx deductible	$70 (each fill/refill applies to the 5-prescription limit)	$50 after Rx deductible
Rx–non-preferred brand drugs (Tier 3)	50% after Rx deductible	50% after Rx deductible	60% (each fill/refill applies to the 5-prescription limit)	50% after Rx deductible
Rx–specialty drugs (Tier 4)	50% up to $150 after Rx deductible	50% up to $150 after Rx deductible	60% up to $150 (each fill/refill applies to the 5-prescription limit)	50% up to $150 after Rx deductible
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	$50 after deductible	$50 after deductible	$50 after deductible	$80
Emergency room	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	$80 after deductible	$80 after deductible	$100 (applies to 10-visit limit)	$80 after deductible
Pediatric Dental Services				
Periodic oral evaluation	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	$40	$40	Not covered	$40
Frames	No charge[2]	No charge[2]	Not covered	No charge[2]
Lenses	No charge[2]	No charge[2]	Not covered	No charge[2]
Contacts	No charge[3]	No charge[3]	Not covered	No charge[3]
Adult Vision Services				
Routine eye exam with optometrist	$40	$40	Not covered	$40
Frames	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Lenses	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]
Contacts	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price[4]

For details about (ia), (ie), and (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).
All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

SILVER PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Silver[ic] 2,000/30/HSA/Vision	KP DC Silver[ic] 3,000/30/HSA/Vision	KP DC Silver Added Choice[id] 2,500/250 RxDed/40		KP DC Silver Virtual Forward 3,000
			In-Network	Out-of-Network	
Individual plan annual deductible (subscriber only)	$2,000	$3,000	$2,500	$5,000	$3,000
Family plan annual deductible (individual/family)	N/A (individual)/$4,000	N/A (individual)/$6,000	$2,500/$5,000	$5,000/$10,000	$3,000/$6,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	100%/0%	70%/30%	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	7,500	7,500	$9,100	$18,200	$8,650
Family plan annual out-of-pocket maximum (individual/family)	$7,500/$15,000	$7,500/$15,000	$9,100/$18,200	$18,200/$36,400	8,650/$17,300
Network[iii]	Signature only	Signature only	Signature only	Not applicable	Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit (copay waived for children under 5 years old)	$30 after deductible	$30 after deductible	$40	$70	No charge for the first visit, then $40 after deductible
Specialty care office visit	$40 after deductible	$40 after deductible	$80	$120	$80 after deductible
Preventive care/screening/immunization	No charge	No charge	No charge	No charge after deductible	No charge
X-ray and lab diagnostic services	$40 after deductible	$40 after deductible	X-ray $80/Lab $40	30% after deductible	X-ray $80/Lab $40 (after deductible)
MRI/CT/PET	$400 after deductible	$400 after deductible	$400 after deductible	30% after deductible	$400 after deductible
Telehealth	No charge after deductible	No charge after deductible	No charge	Applicable cost shares will apply based on type of provider	No charge
Outpatient facility fee	$300 after deductible	$300 after deductible	$350 after deductible	30% after deductible	$350 after deductible
Mental health/chemical dependency outpatient services	$30 individual therapy $15 group therapy (after deductible)	$30 individual therapy $15 group therapy (after deductible)	$40 individual therapy $20 group therapy	$70 individual therapy $35 group therapy	No charge for the first visit, then $40 individual therapy after deductible/$20 group therapy after deductible
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	No charge after deductible	No charge
Inpatient Services					
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per day up to 3 days per admission after deductible	$500 per day up to 3 days per admission after deductible	$500 per day up to 3 days per admission after deductible	30% after deductible	$500 per day up to 3 days per admission after deductible
Prescription Drugs (30-day supply)					
Rx–deductible	Medical deductible applies	Medical deductible applies	$250	Medical deductible applies	Medical deductible applies
Rx–generic drugs (Tier 1)	$20 after deductible	$20 after deductible	$20	30% after deductible	$20 after deductible
Rx–preferred brand drugs (Tier 2)	$50 after deductible	$50 after deductible	$50 after Rx deductible	30% after deductible	$50 after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Silver[ic] 2,000/30/HSA/Vision**	**KP DC Silver[ic] 3,000/30/HSA/Vision**	**KP DC Silver Added Choice[id] 2,500/250 RxDed/40**		**KP DC Silver Virtual Forward 3,000**
			In-Network	**Out-of-Network**	
Prescription Drugs (30-day supply) (Cont.)					
Rx–non-preferred brand drugs (Tier 3)	50% after deductible	50% after deductible	50% after Rx deductible	50% after deductible	50% after deductible
Rx–specialty drugs (Tier 4)	50% up to $150 after deductible	50% up to $150 after deductible	50% up to $150 after Rx deductible	50% up to $150 after deductible	50% up to $150 after deductible
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	$40 after deductible	$40 after deductible	$80	$120	$80 after deductible
Emergency room	$400 after deductible (waived if admitted)	$400 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	$40 after deductible	$40 after deductible	$80 after deductible	$100 after deductible	$80 after deductible
Pediatric Dental Services					
Periodic oral evaluation	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services					
Routine eye exam with optometrist	$30 after deductible	$30 after deductible	$40	$70	No charge for the first visit, then $40 after deductible
Frames	No charge after deductible[2]	No charge after deductible[2]	No charge[2]	30% after deductible[2]	No charge[2]
Lenses	No charge after deductible[2]	No charge after deductible[2]	No charge[2]	30% after deductible[2]	No charge[2]
Contacts	No charge after deductible[3]	No charge after deductible[3]	No charge[3]	30% after deductible[2]	No charge[3]
Adult Vision Services					
Routine eye exam with optometrist	$30 after deductible	$30 after deductible	$40	$70	No charge for the first visit, then $40 after deductible
Frames	Not covered	Not covered	$125 discount off retail price[4]	10% discount off retail price	$125 discount off retail price[4]
Lenses	Not covered	Not covered	$125 discount off retail price[4]	10% discount off retail price	$125 discount off retail price[4]
Contacts	Not covered	Not covered	$125 discount off retail price[4]	5% discount off retail price	$125 discount off retail price[4]

For details about (ic), (id), and (iii), see the Definitions section on page 23.

[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.

[2]One pair per year from a selected group of frames.

[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

SILVER PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Silver 4,850/ 350 RxDed/40/20%**
Individual plan annual deductible (subscriber only)	$4,850
Family plan annual deductible (individual/family)	$4,850/$9,700
Member coinsurance (plan pays/member pays), except as otherwise indicated	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$8,850
Family plan annual out-of-pocket maximum (individual/family)	$8,850/$17,700
Network[iii]	Signature only
HSA/HRA employer-required contribution	Not applicable
BENEFITS	
Outpatient Services	
Primary care office visit (copay waived for children under 5 years old)	$40 (not waived for children under age 5)
Specialty care office visit	$80
Preventive care/screening/immunization	No charge
X-ray and lab diagnostic services	X-ray $80/Lab $60
MRI/CT/PET	$400
Telehealth	No charge
Outpatient facility fee	20% after deductible
Mental health/chemical dependency outpatient services	$40 individual therapy $20 group therapy
Maternity Services	
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge
Inpatient Services	
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	20% after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Silver 4,850/40/20%/Vision**
Prescription Drugs (30-day supply)	
Rx–deductible	$350
Rx–generic drugs (Tier 1)	$20
Rx–preferred brand drugs (Tier 2)	$50 after Rx deductible
Rx–non-preferred brand drugs (Tier 3)	$70 after Rx deductible
Rx–specialty drugs (Tier 4)	$150 after Rx deductible
Urgent Care and Emergency Services	
Urgent care centers (after-hours urgent care)	$90
Emergency room	$400 after deductible (waived if admitted)
Therapy and Rehabilitation Services	
Habilitative and rehabilitative services	$65
Pediatric Dental Services	
Periodic oral evaluation	$0[1]
Prophylaxis (cleaning)	$0[1]
Topical application of fluoride	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services	
Routine eye exam with optometrist	No charge
Frames	No charge[2]
Lenses	No charge[2]
Contacts	No charge[3]
Adult Vision Services	
Routine eye exam with optometrist	$40
Frames	$90 discount off retail price[4]
Lenses	$90 discount off retail price[4]
Contacts	$25 discount off retail price[4]

For details about (iii), see the Definitions section on page 23.

[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.

[2]One pair per year from a selected group of frames.

[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

BRONZE PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC).*

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Bronze[ia] 6,500/55/Vision**	**KP DC Bronze[ic] 6,000/50/ HSA/Vision**	**KP DC Bronze[ic] 7,050/0%/HSA/Vision**	**KP DC Bronze Added Choice[id] 6,500/55/POS/Vision**	
				In-Network	**Out-of-Network**
Individual plan annual deductible (subscriber only)	$6,500	$6,000	$7,050	$6,500	$13,000
Family plan annual deductible (individual/family)	$6,500/$13,000	$6,000/$12,000	$7,050/$14,100	$6,500/$13,000	$13,000/$26,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	100%/0%	100%/0%	60%/40%
Individual plan annual out-of-pocket maximum (subscriber only)	$9,100	$7,200	$7,050	$9,100	$18,200
Family plan annual out-of-pocket maximum (individual/family)	$9,100/$18,200	$7,200/$14,400	$7,050/$14,100	$9,100/$18,200	$18,200/$36,400
Network[iii]	Signature only	Signature only	Signature only	Signature only	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit (copay waived for children under 5 years old)	$55	$50 after deductible	No charge after deductible	$55	40% after deductible
Specialty care office visit	$80	$70 after deductible	No charge after deductible	$80	40% after deductible
Preventive care/screening/immunization	No charge	No charge	No charge	No charge	40% after deductible
X-ray and lab diagnostic services	X-ray $200/Lab $80 (after deductible)	X-ray $70/Lab $50 (after deductible)	No charge after deductible	X-ray $200/Lab $80 (after deductible)	40% after deductible
MRI/CT/PET	$500 after deductible	$400 after deductible	No charge after deductible	$500 after deductible	40% after deductible
Telehealth	No charge	No charge after deductible	No charge after deductible	No charge	40% after deductible
Outpatient facility fee	$200 after deductible	$300 after deductible	No charge after deductible	$200 after deductible	40% after deductible
Mental health/chemical dependency outpatient	$55 individual therapy $27 group therapy	$50 individual therapy $25 group therapy (after deductible)	No charge after deductible	$55 individual therapy $27 group therapy	40% after deductible
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	No charge	40% after deductible
Inpatient Services					
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per day up to 3 days per admission after deductible	$500 per admission after deductible	No charge after deductible	$500 per day up to 3 days per admission after deductible	40% after deductible

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP DC Bronze[ia] 6,500/55/Vision	KP DC Bronze[ic] 6,000/50/ HSA/Vision	KP DC Bronze[ic] 7,050/0%/HSA/Vision	KP DC Bronze Added Choice[id] 6,500/55/POS/Vision	
				In-Network	Out-of-Network
Prescription Drugs (30-day supply)					
Rx–deductible	Medical deductible applies	Medical deductible applies	Medical deductible applies	Medical deductible applies	Medical deductible applies
Rx–generic drugs (Tier 1)	$35	$25 after deductible	No charge after deductible	$35	40% after deductible
Rx–preferred brand drugs (Tier 2)	$100 after deductible	$45 after deductible	No charge after deductible	$100 after deductible	40% after deductible
Rx–non-preferred brand drugs (Tier 3)	50% after deductible	$65 after deductible	No charge after deductible	50% after deductible	50% after deductible
Rx–specialty drugs (Tier 4)	50% up to $150 after deductible	50% up to $150 after deductible	No charge after deductible	50% up to $150 after deductible	50% up to $150 after deductible
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	$80	$70 after deductible	No charge after deductible	$80	40% after deductible
Emergency room	$500 after deductible (waived if admitted)	$250 after deductible (waived if admitted)	No charge after deductible	$500 after deductible (waived if admitted)	$500 after deductible (waived if admitted)
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	$80 after deductible	$70 after deductible	No charge after deductible	$80 after deductible	40% after deductible
Pediatric Dental Services					
Periodic oral evaluation	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Prophylaxis (cleaning)	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Topical application of fluoride	$0[1]	$0[1]	$0[1]	$0[1]	Not covered
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered
Pediatric Vision Services					
Routine eye exam with optometrist	$55	$50 after deductible	No charge after deductible	$55	40% after deductible
Frames	No charge[2]	No charge after deductible[2]	No charge after deductible[2]	No charge[2]	40% after deductible[2]
Lenses	No charge[2]	No charge after deductible[2]	No charge after deductible[2]	No charge[2]	40% after deductible[2]
Contacts	No charge[3]	No charge after deductible[3]	No charge after deductible[3]	No charge[3]	40% after deductible[3]
Adult Vision Services					
Routine eye exam with optometrist	$55	$50 after deductible	No charge after deductible	$55	40% after deductible
Frames	$125 discount off retail price[4]	Not covered	Not covered	$125 discount off retail price[4]	10% discount off retail price
Lenses	$125 discount off retail price[4]	Not covered	Not covered	$125 discount off retail price[4]	10% discount off retail price
Contacts	$125 discount off retail price[4]	Not covered	Not covered	$125 discount off retail price[4]	5% discount off retail price

For details about (ia), (ic), (id), and (iii), see the Definitions section on page 23.

[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.

[2]One pair per year from a selected group of frames.

[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Bronze 7,500/850 RxDed/45/40%**	**KP DC Standard Bronze 6,350/20%/HSA/Vision**
Individual plan annual deductible (subscriber only)	$7,500	$6,350
Family plan annual deductible (individual/family)	$7,500/$15,000	$6,350/$12,700
Member coinsurance (plan pays/member pays), except as otherwise indicated	60%/40%	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$9,150	$7,200
Family plan annual out-of-pocket maximum (individual/family)	$9,150/$18,300	$7,200/$14,400
Network[iii]	Signature only	Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable
BENEFITS		
Outpatient Services		
Primary care office visit (copay waived for children under 5 years old)	$45 (not waived for childen under age 5)	20% after deductible
Specialty care office visit	$105	20% after deductible
Preventive care/screening/immunization	No charge	No charge
X-ray and lab diagnostic services	X-ray $80/ Lab $55 (after deductible)	20% after deductible
MRI/CT/PET	$500 after deductible	20% after deductible
Telehealth	No charge	No charge after deductible
Outpatient facility fee	40% after deductible	20% after deductible
Mental health/chemical dependency outpatient	$45 individual therapy $22 group therapy	20% after deductible
Maternity Services		
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge
Inpatient Services		
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	40% after deductible	20% after deductible

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP DC Standard Bronze 7,500/45/40%/Vision**	**KP DC Standard Bronze 6,350/20%/ HSA/Vision**
Prescription Drugs (30-day supply)		
Rx—deductible	$850	Medical deductible applies
Rx—generic drugs (Tier 1)	$25	20% after deductible
Rx—preferred brand drugs (Tier 2)	$75 after Rx deductible	20% after deductible
Rx—non-preferred brand drugs (Tier 3)	$100 after Rx deductible	20% after deductible
Rx—specialty drugs (Tier 4)	$150 after Rx deductible	20% up to $150 after deductible
Urgent Care and Emergency Services		
Urgent care centers (after-hours urgent care)	$100	20% after deductible
Emergency room	40% after deductible	20% after deductible
Therapy and Rehabilitation Services		
Habilitative and rehabilitative services	$50 after deductible	20% after deductible
Pediatric Dental Services		
Periodic oral evaluation	$0[1]	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]
Topical application of fluoride	$0[1]	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services		
Routine eye exam with optometrist	$50	$50 after deductible
Frames	No charge[2]	No charge after deductible[2]
Lenses	No charge[2]	No charge after deductible[2]
Contacts	No charge[3]	No charge after deductible[3]
Adult Vision Services		
Routine eye exam with optometrist	$45	20% after deductible
Frames	$90 discount off retail price[4]	Not covered
Lenses	$90 discount off retail price[4]	Not covered
Contacts	$25 discount off retail price[4]	Not covered

For details about (iii), see the Definitions section on page 23.
[1]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[2]One pair per year from a selected group of frames.
[3]In lieu of lenses/frames. Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.
[4]Adult vision hardware discount is available either for frames and lenses combined or contact lenses once per year (365 days).

All cost sharing for listed services except Adult Vision Services is applied to the out-of-pocket maximum. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum. This statement does not apply to out-of-network services or HSA-qualified plans.

DEFINITIONS

(ia) Deductible HMO Plans

Deductible plans with family coverage have both an individual deductible and a family deductible. That means that one member of the family can meet the lower individual deductible and be eligible for coinsurance or copayments before the higher family deductible is satisfied. Similarly, one family member can meet the lower individual out-of-pocket maximum before the higher family out-of-pocket maximum is met. Services subject to the deductible are marked with "after deductible" along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(ib) HSA-Qualified Deductible HMO Plans

Under certain HSA-qualified deductible plans with family coverage, there is no individual member deductible or out-of-pocket maximum. Instead, all plans are subject to a family deductible or out-of-pocket maximum, which can be met by one or more family members contributing to a combined family deductible or out-of-pocket maximum. Once the combined contribution of all family members has reached the applicable deductible or out-of-pocket maximum, the deductible/out-of-pocket maximum will be satisfied for all family members for the remainder of the contract year. Services subject to the deductible are marked with "after deductible" along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(ic) HSA-Qualified Deductible HMO Plans

Under certain HSA-qualified deductible plans with family coverage, there is both an individual member deductible and out-of-pocket maximum. That means that one member of the family can meet the lower individual deductible and be eligible for coinsurance or copayments before the higher family deductible is satisfied. Similarly, one family member can meet the lower individual out-of-pocket maximum before the higher family out-of-pocket maximum is met. Services subject to the deductible are marked with "after deductible" along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(id) Added Choice Plans

Added Choice point-of-service plans combine an in-network provider option with an out-of-network provider option. Members can switch between the two provider network options at any time. Benefits vary between each option, and the cost sharing for a particular service depends on the provider option and, sometimes, where the member receives care.

(ie) Kaiser Permanente Plus Plans

Kaiser Permanente Plus and Deductible Kaiser Permanente Plus plans are traditional HMO/DHMO plans with an added benefit, called the out-of-network benefit, that gives members the ability to see any licensed provider in the nation for certain covered outpatient services annually (visit limits apply).

(iii) Kaiser Permanente Signature

With the Kaiser Permanente Signature provider network, you receive quality care provided by our Permanente physicians—a network of physicians in the Mid-Atlantic Permanente Medical Group, P.C., 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, you have convenient access to contracted hospitals located throughout the service area. When you receive care, tests, and screenings in our medical centers, you can use **kp.org** to email your doctor's office, check most lab results, schedule and cancel appointments, order prescription refills for mail delivery or pickup, and much more.

(iii) Kaiser Permanente Select

Building on our Signature physician network, Kaiser Permanente 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.

SECTION 3: BENEFITS, EXCLUSIONS AND LIMITATIONS

1. Accidental Dental Injury Services

Benefit-Specific Exclusion:

- An injury that results from chewing or biting is not considered an Accidental Injury under this Plan.

2. Ambulance Services

Benefit-Specific Exclusions:

- Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider; and
- Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

3. Anesthesia for Dental Services

Benefit-Specific Exclusion:

- The dentist's or Specialist's professional Services.

4. Blood, Blood Products and Their Administration

Benefit-Specific Limitation:

- Member recipients must be designated at the time of procurement of cord blood.

Benefit-Specific Exclusion:

- Directed blood donations.

5. Clinical Trials

Benefit-Specific Exclusions:

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.

6. Diabetic Equipment, Supplies, and Self-Management

Benefit-Specific Limitations:

Diabetic equipment and supplies are limited to the Health Plan's preferred equipment and supplies unless the equipment or supply:

- Was prescribed by a Plan Provider; and
  - » There is no equivalent preferred equipment or supply available; or
  - » An equivalent preferred equipment or supply has:
    - Been ineffective in treating the disease or condition of the Member; or
    - Caused or is likely to cause an adverse reaction or other harm to the Member.

"Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

7. Drugs, Supplies, and Supplements

Benefit-Specific Exclusions:

- Drugs, supplies and supplements that can be self-administered or do not require administration or observation by medical personnel;
- Drugs for which a prescription is not required by law; and
- Drugs for the treatment of sexual dysfunction disorders.

8. Durable Medical Equipment

Benefit-Specific Exclusions:

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Non-medical items such as sauna baths or elevators;
- Modifications to your home or car;
- Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation; and
- Services not preauthorized by the Health Plan.

9. Emergency Services, Including Emergency Services HIV Screening Test

Benefit-Specific 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 forty-eight (48) hours or the next business day, whichever is later, or 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.
- **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 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, if applicable, will not be waived.

10. Habilitative Services

Benefit-Specific Exclusions:

- Assistive technology Services and devices;
- Services provided through federal, state or local early intervention programs, including school programs;
- Services not preauthorized by the Health Plan;
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced; and
- Services not provided by a licensed or certified therapist.

11. Hearing Services

Benefit-Specific Exclusions:

- Tests to determine an appropriate hearing aid; and
- Hearing aids or tests to determine their efficacy.

12. Home Health Care Services

Benefit-Specific Exclusions:

- Custodial care (see definition under "Exclusions" in this section);
- Routine administration of oral medications, eye drops and/or ointments;
- General maintenance care of colostomy, ileostomy and ureterostomy;
- Medical supplies or dressings applied by a Member or family caregiver;
- Corrective appliances, artificial aids and orthopedic devices;

- Homemaker Services;
- Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility and we provide or offer to provide that care in one of these facilities;
- Services not preauthorized by Health Plan; and
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

13. Hospice Care Services

Benefit-Specific Limitation:

- Hospice Care Services are limited to a maximum of one-hundred eighty (180) days per eligibility period. The hospice eligibility period begins on the first date hospice care services are rendered and terminates 180 days later or upon the death of the terminally ill Member, if sooner. If the Member requires an extension of the eligibility period, we will extend the eligibility period on an individual case basis, if we determine that the Member's prognosis and continued need for services are consistent with a program of hospice care services.

14. Infertility Diagnostic Services

Benefit-Specific Exclusions:

- Artificial insemination, in vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure;
- Infertility drugs used in assisted reproductive technology (ART) procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
- Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple;
- Fallopian scar revision surgery.

15. Maternity Services

Benefit-Specific Exclusion:

- Services for newborn deliveries performed at home.

17. Mental Health Services and Substance Use Disorder

Benefit-Specific Exclusions:

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse or drug addiction, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

18. Morbid Obesity Services, Including Bariatric Surgery

Benefit-Specific Exclusion:

- Services not preauthorized by the Health Plan.

19. Oral Surgery

Benefit-Specific Exclusions:

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery;
- Lab fees associated with cysts that are considered dental under our standards;
- Orthodontic Services; and
- Dental appliances.

20. Preventive Health Care Services

Benefit-Specific Limitations:

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, not listed above under preventive health Services, for which you have been determined to be at high risk for contracting based on factors by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits;
- Lab, imaging, and other ancillary Services not included in routine prenatal care;
- Non-preventive Services performed in conjunction with a sterilization;
- Lab, imaging, and other ancillary Services associated with male sterilizations. Lab, imaging, and other ancillary Services that are an integral part of a preventive service, such as a preventive colonoscopy or female sterilization, will be covered without cost sharing;
- Complications that arise after a sterilization procedure;
- Treatment of a medical condition or problem identified during the course of a preventive screening exam;
- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles and carrier cases;
- Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment; and
- Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

21. Prosthetic and Orthotic Devices

Benefit-Specific Limitations:

- Coverage for mastectomy bras is limited to a maximum of four (4) per [calendar][contract] [policy] year.
- [Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of $350 per prosthesis.]
- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
- Therapeutic shoes and inserts are covered when deemed medically necessary by a Plan Provider, and are limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation.

Benefit-Specific Exclusions:

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- Repair or replacement of prosthetics devices due to loss or misuse.
- Hair prostheses.
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet the Health Plan criteria as Medical Necessary.
- Multifocal intraocular lens implants.
- More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
- Dental prostheses, devices and appliances, except as specifically provided in this section, or as provided under an "Adult Dental Plan Appendix" or a "Pediatric Dental Plan Appendix," if applicable.
- Hearing aids, except as specifically provided in this section.
- Corrective lenses and eyeglasses, except as specifically provided in this section.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
- Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts.
- Comfort, convenience, or luxury equipment or features.

22. Reconstructive Surgery

Benefit-Specific Exclusions:

Cosmetic surgery, plastic surgery or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance or are not likely to result in significant improvement in physical function, and are not Medically Necessary. Examples of excluded cosmetic dermatology services are:

- Removal of moles or other benign skin growths for appearance only;
- Chemical peels; and
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

23. Routine Foot Care

Benefit-Specific Limitation:

- Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Benefit-Specific Exclusion:

- Routine foot care Services that are not Medically Necessary.

24. Skilled Nursing Facility Care

Benefit-Specific Exclusions:

- Custodial care (definition in this section).
- Domiciliary care.

25. Telemedicine Services

Benefit-Specific Exclusion:

- Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

26. Therapy and Rehabilitation Services

Benefit-Specific Limitations:

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.
- Physical therapy is limited to the restoration of a physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under "Habilitative Services" in this section;
- The limitations listed immediately above for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Benefit-Specific Limitations:

- Long-term rehabilitation therapy.
- Except as provided for cardiac and pulmonary rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a ninety (90)-day period.

27. Transplant Services

Benefit-Specific Exclusion:

- Services related to non-human or artificial organs and their implantation.

28. Urgent Care Services

Benefit-Specific Exclusion:

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

29. Vision Services

Benefit-Specific Exclusions:

- Industrial and athletic safety frames;
- Eyeglass lenses and contact lenses with no refractive value;
- Sunglasses without corrective lenses unless Medically Necessary;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures);
- Eye exercises;
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;
- Replacement of lost, broken or damaged lenses frames and contact lenses;
- Plano lenses;
- Lens adornment, such as engraving, faceting or jewelling;
- Low-vision devices;
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits; and
- Orthoptic (eye training) therapy.

MEDICAL EXCLUSIONS

This provision provides information on what Services the Health Plan will not pay for regardless of whether or not the Service is Medically Necessary.

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section. When a Service is not covered, all Services, drugs, or supplies related to the non-covered Service are excluded from coverage, except Services we would otherwise cover to treat direct complications of the non-covered Service.

For example, if you have a non-covered cosmetic surgery, we will not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication, such as a serious infection, this exclusion would not apply and we will cover any Services that we will otherwise cover to treat that complication.

The following Services are excluded from coverage:

1. **Certain Alternative Medical Services,** except when used for anesthesia: acupuncture Services and any other Services of an Acupuncturist, Naturopath, and Massage Therapist.
2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, or licensing; or
   c. On court-order or required for parole or probation.
3. **Cosmetic Services,** including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.
4. **Custodial Care,** meaning assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
5. **Disposable Supplies** for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices not specifically listed as covered in this Section.
6. **Durable Medical Equipment,** except for Services covered under "Durable Medical Equipment" in the List of Benefits in this Section.
7. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.
8. **Experimental or Investigational Services:** Except as covered under Clinical Trials in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:
   a. It cannot be legally marketed in the United States without the approval of the federal Food and Drug Administration (FDA) and such approval has not been granted; or
   b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
   c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of Services; or
   d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

   In determining whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
   a. your medical records;
   b. the written protocols or other documents pursuant to which the Service has been or will be provided;
   c. any consent documents you or your representative has executed or will be asked to execute, to receive the Service;
   d. the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
   e. the published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury; and
   f. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   The Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.
9. **External Prosthetic and Orthotic Devices:** Services and supplies for external prosthetic and orthotic devices, except as specifically covered under this section of this Agreement.
10. **Infertility Services:**
    a. Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures.
    b. Any Services or supplies provided to a person not covered under your Health Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
    c. Drugs used to treat infertility.
11. **Prohibited Referrals:** Payment of any claim, bill, or other demand or request for payment for covered Services determined to be furnished as the result of a referral prohibited by law.
12. **Services for Members in the Custody of Law Enforcement Officers:** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Emergency Services.
13. **Travel and Lodging Expenses.**
14. **Worker's Compensation or Employer Liability:**

Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the Services or supplies. Sources of coverage or reimbursement may include your employer, worker's compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a worker's compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

MEDICAL LIMITATIONS

We will make our best efforts to provide or arrange for your health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot: means a public disturbance involving an assemblage of five (5) or more persons which by tumultuous and violent conduct or the threat thereof creates grave danger of damage or injury to property or persons. An exclusion or limitation for riot shall apply only when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide the Services covered under this Agreement, the Health Plan, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente's Medical Group Plan Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a Member in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, they will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under **Getting a Second Opinion** in **Section 2 – How to Get the Care You Need.** If you still refuse to accept the recommended Services, the Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

PHARMACY EXCLUSIONS

Exclusions

Except as specifically covered under this Outpatient Prescription Drug Benefit, the Health Plan does not cover a drug:

1. Weight management drugs;
2. Sexual dysfunction drugs;
3. A drug that can be obtained without a prescription, except for over-the-counter contraceptive drugs; or
4. A drug for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits.

Dispensing Limitations

Except for Maintenance Medications as described below, Members may obtain up to a thirty (30)-day supply for drugs other than contraceptive drugs and will be charged the applicable Copayment or Coinsurance based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

For contraceptive drugs, Members may obtain up to a twelve (12)-month supply at one time at no charge.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one Cost Share at the initial dispensing for each thirty (30)-day supply.

Except for Maintenance Medications and contraceptive drugs as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

Maintenance Medication Dispensing Limitations

Members may obtain up to a ninety (90)-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Limitations and Exclusions

LIMITATIONS

Benefits are subject to the following limitations:

1. For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a Plan Pharmacy or a Participating Network Pharmacy, unless the criteria for coverage of Non-Preferred Drugs has been met. The Non-Preferred Drug coverage criteria is detailed in this Outpatient Prescription Drug Benefit in the subsection titled, "Preferred vs. Non-Preferred Drugs."

2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in **Section 5 – Filing Claims, Appeals and Grievances.** Claims should be submitted to:

   Kaiser Permanente National Claims
   Administration – Mid Atlantic States
   P.O. Box 371860
   Denver, CO 80237-9998

EXCLUSIONS

The following are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*. Please refer to the applicable benefit to determine if drugs are covered:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Formulary.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Formulary.
3. Drugs obtained from a non-Plan Pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered or associated with a covered authorized referral outside the Service Area.
4. Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to **Hospital Inpatient Care** and **Skilled Nursing Facility Care** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
5. Drugs that are not listed in our Formulary, except as described in this Prescription Drug Benefit.
6. Drugs that are considered to be experimental or investigational. Refer to **Clinical Trials** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
7. Covered Services of your Group *Evidence of Coverage*.
8. Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug which can be obtained without a prescription, or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug.
9. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
10. Blood or blood products. Refer to **Blood, Blood Products and their Administration** in Section 3 – Benefits, Exclusions and Limitations of your Group *Evidence of Coverage*.
11. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including, but not limited to, drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
12. Medical foods. Refer to **"Medical Foods"** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
13. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to **Hospice Care** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
14. Replacement prescriptions necessitated by theft or loss.
15. Prescribed drugs and accessories that are necessary for Services that are excluded under this Group *Evidence of Coverage*.
16. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
17. Alternative formulations or delivery methods that are different from the Health Plan's standard formulation or delivery method for prescription drugs and deemed not Medically Necessary.
18. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to **Durable Medical Equipment** and **Prosthetic Devices** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
19. Drugs and devices that are provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to **Drugs, Supplies, and Supplements** and **Home Health Services** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
20. Bandages or dressings. Refer to **Drugs, Supplies, and Supplements** and **Home Health Services** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
21. Diabetic equipment and supplies. Refer to **Diabetic Equipment Supplies, and Self-Management** in **Section 3 – Benefits, Exclusions and Limitations** of this Group *Evidence of Coverage*.
22. Growth hormone therapy for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
23. Immunizations and vaccinations solely for the purpose of travel. Refer to **Outpatient Care** in **Section 3 – Benefits, Exclusions and Limitations** of your Group *Evidence of Coverage*.
24. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.
25. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
26. Drugs for the treatment of infertility.

DENTAL GENERAL EXCLUSIONS

The following exclusions apply to covered dental services for children under age nineteen (19) years:

1. Any procedures not listed on this Plan.
2. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
3. Dental procedures or services performed solely for Cosmetic purposes or that is not dentally necessary and/or medically necessary; unless the member has purchased the additional Cosmetic OrthoPlus Plan and services are within the benefit guidelines listed in the Cosmetic OrthoPlus Plan.
4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Plan based on generally accepted dental standards of care.
5. For elective procedures, including prophylactic extraction of third molars.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged.
7. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
8. Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as a Covered Service.

9. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
10. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
11. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
12. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
13. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.
14. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded from Orthodontic benefits.
15. Broken appointments unless specifically covered.

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 nià 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**）。

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**).

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

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

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

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

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

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

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

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

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

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

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

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

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

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. 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 **1-888-225-7202** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company 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: KPIC Civil Rights Coordinator, Grievance 1557, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736, telephone number 1-888-225-7202.

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 **1-888-225-7202** (TTY: **711**).

አማርኛ (Amharic) ያስተውሉ፡ እንግሊዘኛ የሚናገሩ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ ከክፍያ ነጻ፣ ለእርስዎ ይገኛሉ። ወደ **1-888-225-7202** ይደውሉ (TTY: **711**)።

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বাংলা (Bengali) মনোযোগ দিন: যদি আপনি ইংরেজিতে কথা বলেন, আপনার জন্য ভাষা সহায়তা পরিষেবা, বিনামূল্যে উপলব্ধ। **1-888-225-7202** (TTY: **711**) এ কল করুন|

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言協助服務。請致電 **1-888-225-7202**（TTY：**711**）

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با شماره **1-888-225-7202** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-225-7202** (TTY: **711**).

KPIC-NDT-2022-014-MD-VA-DC

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen eine kostenlose Sprachassistenz zur Verfügung. Bitte wählen Sie: **1-888-225-7202** (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો ભાષા સહાય સેવાઓ, વિના મૂલ્યે, આના પર ઉપલબ્ધ છે તમે. **1-888-225-7202** (TTY: **711**) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-225-7202** (TTY: **711**).

हिंदी (Hindi) ध्यान दें: यदि आप अंग्रेजी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-225-7202** (टीटीवाई: **711**) पर कॉल करें।

Igbo (Igbo) GEE NTI: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka nkowa asụsụ, du n'efu, dịrị gị. Kpọọ **1-888-225-7202** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-225-7202** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-888-238-5742** (TTY: **711**)

日本語 (Japanese) 注意事項: 日本語を話される場合、言語支援サービスを無料でご利用いただけます。**1-888-225-7202** (TTY: **711**)まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-225-7202** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koj ʼ hódíílnih **1-888-225-7202** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis de forma gratuita serviços linguísticos. Basta ligar para **1-888-225-7202** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните **1-888-225-7202** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-225-7202** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-225-7202** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากคุณพูดภาษาอังกฤษ คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร **1-888-225-7202** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ انگریزی زبان بولتے ہیں، تو لسانی معاونت کی خدمات، بلامعاوضہ، آپ کے لیے دستیاب ہیں۔ **1-888-225-7202** (TTY: **711**) پر کال کریں۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-225-7202** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun o. Pe **1-888-225-7202** (TTY: **711**)

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