# Small Business Plan Summaries | MARYLAND | 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 KP Plus | Added Choice 2-Tier POS | Flexible Choice 3-Tier POS[1] |
|---|---|---|---|---|---|---|
| **Product features** | • Lowest cost plans at premium level<br>• Option for tax-advantaged savings account<br>• IRS-regulated minimum deductible<br>• All benefits subject to deductible | • $0 virtual visits<br>• Small number of in-person primary care visits each year at no or low cost<br>• In-person preventive care at no charge<br>• No referrals needed for in-person care | • Well-priced and quality health care with very predictable costs<br>• Minimal costs subject to deductible<br>• Broad range of deductibles and copays<br>• Also available in the Select care system: more community providers than that for core Signature | • In-network: Identical to comprehensive Kaiser Permanente HMO<br>• Coverage outside Kaiser Permanente for up to 10 outpatient visits a year (limits apply)<br>• Up to 5 pharmacy fills a year at facilities outside Kaiser Permanente<br>• Price advantage compared to Added Choice and Flexible Choice | • In-network: Identical to comprehensive Kaiser Permanente HMO<br>• Out-of-network: any licensed provider in the US<br>• No referrals needed to see a specialist in Tier 2<br>• Choice of provider each time care is sought<br>• Competitive option that fits needs of all employees | • In-network Tier 1: Identical to comprehensive Kaiser Permanente HMO<br>• In-network Tier 2: Curated national PPO network<br>• Out-of-network: Any licensed provider in US<br>• No referrals required for specialists in Tiers 2 and 3<br>• 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<br>• Are willing to pay higher out-of-pocket costs at point of care<br>• Are in a workforce with relatively low care needs<br>• Are close to and/or contained within the Kaiser Permanente delivery footprint | • Seek the convenience of virtual-oriented care model<br>• Need to limit upfront benefit costs<br>• Desire a degree of pre-deductible primary care coverage<br>• Are in savvy workforce with low in-person care needs | • Value quality and the convenience of fully integrated model<br>• Seek to balance premium cost and comprehensive coverage<br>• 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<br>• Are new to integrated care, trying out options<br>• 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)<br>• Sole carrier groups<br>• Have a strong preference for choice<br>• Have experience with two-tier products<br>• Have larger groups with most employees within and around the Kaiser Permanente footprint | • Have a broad range of employees with divergent needs<br>• Have senior leaders who need choice and/or employment benefit<br>• Are new to integrated care with strong choice preference<br>• Have employees who travel often outside the Kaiser Permanente footprint<br>• 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

## Maryland 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)*.

KP Offered through Kaiser Permanente  S Offered through Small Business Options Program (SHOP), Maryland Health Connection

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Platinum 0/10/Vision** | KP<br>**KP MD Platinum[ig] Plus 0/10/Vision** | | KP S<br>**KP MD Platinum[ia] 500/20/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) | $2,650 | $2,650 | Not applicable | $2,700 |
| Family plan annual out-of-pocket maximum (individual/family) | $2,650/$5,300 | $2,650/$5,300 | Not applicable | $2,700/$5,400 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature only | Not applicable | KP Signature or Select<br>S Signature only |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | |
| **Outpatient Services** | | | | |
| Primary care office visit | $10 | $10 | $30 (applies to 10-visit limit) | $20 |
| Specialty care office visit | $30 | $30 | $50 (applies to 10-visit limit) | $30 |
| Preventive care/screening/immunization | No charge | No charge | No charge<br>(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<br>(applies to 10-visit limit) | X-ray $30/Lab $20 |
| MRI/CT/PET | $100 | $100 | Not covered | $50 after deductible |
| Telehealth | No charge | No charge | $30 (applies to 10-visit limit) | No charge |
| Outpatient facility fee | $100 | $100 | Not covered | $50 after deductible |
| Mental health/chemical dependency outpatient | $10 individual therapy<br>$5 group therapy | $10 individual therapy<br>$5 group therapy | $30 individual therapy<br>$15 group therapy<br>(applies to 10-visit limit) | $20 individual therapy<br>$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) | $150 per admission | $150 per admission | Not covered | $100 per admission after deductible |

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Platinum 0/10/Vision** | KP<br>**KP MD Platinum(ig) Plus 0/10/Vision** | | KP S<br>**KP MD Platinum(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) | $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) | $25 |
| Rx–non-preferred brand drugs (Tier 3) | $50 | $50 | $70 (each fill/refill applies to the 5-prescription limit) | $50 |
| 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) | $150 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) | $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 | $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 | $10 | $10 | 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), (ig), and (iii), see the Definitions section on page 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## 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)*.

KP Offered through Kaiser Permanente  S Offered through Small Business Options Program (SHOP), Maryland Health Connection

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Gold 0/20/Vision** | KP<br>**KP MD Gold Plus[ig] 0/20/Vision** | | KP<br>**KP MD 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) | $8,850 | $8,850 | Not applicable | $7,750 |
| Family plan annual out-of-pocket maximum (individual/family) | $8,850/$17,700 | $8,850/$17,700 | Not applicable | $7,750/$15,500 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature only | Not applicable | KP Signature or Select |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | |
| **Outpatient Services** | | | | |
| Primary care office visit | $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 | $300 after deductible |
| Telehealth | No charge | No charge | $40 (applies to 10-visit limit) | No charge |
| Outpatient facility fee | $250 | $250 | Not covered | $250 after deductible |
| Mental health/chemical dependency outpatient services | $20 individual therapy<br>$10 group therapy | $20 individual therapy<br>$10 group therapy | $40 individual therapy<br>$20 group therapy<br>(applies to 10-visit limit) | $20 individual therapy<br>$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 S KP MD Gold 0/20/Vision** | **KP MD Gold Plus(ig) 0/20/Vision** | | **KP MD 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) | $50 | $50 | $70 (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 | $300 (waived if admitted) | $300 (waived if admitted) | $300 (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), (ig), and (iii), see the Definitions section on page 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Gold[ia]<br>1,000/100 RxDed/20/Vision** | KP<br>**KP MD Gold[ib]<br>1,500/150 RxDed/20/Vision** | KP<br>**KP MD Gold Plus[ig]<br>1,500/150 RxDed/20/Vision** | |
|---|---|---|---|---|
| | | | **Kaiser Permanente Providers** | **Out-of-Network Providers** |
| Individual plan annual deductible (subscriber only) | $1,000 | $1,500 | $1,500 | Not applicable |
| Family plan annual deductible (individual/family) | $1,000/$2,000 | $1,500/$3,000 | $1,500/$3,000 | Not applicable |
| Member coinsurance (plan pays/member pays), except as otherwise indicated | 100%/0% | 100%/0% | 100%/0% | Not applicable |
| Individual plan annual out-of-pocket maximum (subscriber only) | $7,750 | $7,300 | $7,300 | Not applicable |
| Family plan annual out-of-pocket maximum (individual/family) | $7,750/$15,500 | $7,300/$14,600 | $7,300/$14,600 | Not applicable |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature or Select | KP Signature only | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | |
| **Outpatient Services** | | | | |
| Primary care office visit | $20 | $20 | $20 | $40 (applies to 10-visit limit) |
| Specialty care office visit | $50 | $50 | $50 | $70 (applies to 10-visit limit) |
| Preventive care/screening/immunization | No charge | No charge | No charge | No charge (applies to 10-visit limit) |
| X-ray and lab diagnostic services | $50 | $50 | $50 | $70 (applies to 10-visit limit) |
| MRI/CT/PET | $300 after deductible | $300 after deductible | $300 after deductible | Not covered |
| Telehealth | No charge | No charge | No charge | $40 (applies to 10-visit limit) |
| Outpatient facility fee | $250 after deductible | $250 after deductible | $250 after deductible | Not covered |
| Mental health/chemical dependency outpatient services | $20 individual therapy<br>$10 group therapy | $20 individual therapy<br>$10 group therapy | $20 individual therapy<br>$10 group therapy | $40 individual therapy<br>$20 group therapy<br>(applies to 10-visit limit) |
| **Maternity Services** | | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | No charge | Not covered |
| **Inpatient Services** | | | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $500 per admission after deductible | $500 per admission after deductible | $500 per admission after deductible | Not covered |

## GOLD PLAN SUMMARIES (Cont.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>KP MD Gold[ia]<br>1,000/100 RxDed/20/Vision | KP<br>KP MD Gold[ib]<br>1,500/150 RxDed/20/Vision | KP<br>KP MD Gold Plus[ig]<br>1,500/150 RxDed/20/Vision | |
|---|---|---|---|---|
| | | | Kaiser Permanente Providers | Out-of-Network Providers |
| **Prescription Drugs (30-day supply)** | | | | |
| Rx–deductible | $100 | $150 | $150 | Not applicable |
| Rx–generic drugs (Tier 1) | $10 | $10 | $10 | $30 (each fill/refill applies to the 5-prescription limit) |
| Rx–preferred brand drugs (Tier 2) | $50 after Rx deductible | $50 after Rx deductible | $50 after Rx deductible | $70 (each fill/refill applies to the 5-prescription limit) |
| Rx–non-preferred brand drugs (Tier 3) | $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) | 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) | $50 | $50 | $50 | $50 |
| Emergency room | $350 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 | $50 | $50 | $50 | $70 (applies to 10-visit limit) |
| **Pediatric Dental Services** | | | | |
| Periodic oral evaluation | $0[1] | $0[1] | $0[1] | Not covered |
| Prophylaxis (cleaning) | $0[1] | $0[1] | $0[1] | Not covered |
| Topical application of fluoride | $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] | Not covered |
| **Pediatric Vision Services** | | | | |
| Routine eye exam with optometrist | $20 | $20 | $20 | Not covered |
| Frames | No charge[2] | No charge[2] | No charge[2] | Not covered |
| Lenses | No charge[2] | No charge[2] | No charge[2] | Not covered |
| Contacts | No charge[3] | No charge[3] | No charge[3] | Not covered |
| **Adult Vision Services** | | | | |
| Routine eye exam with optometrist | $20 | $20 | $20 | Not covered |
| Frames | $125 discount off retail price[4] | $125 discount off retail price[4] | $125 discount off retail price[4] | Not covered |
| Lenses | $125 discount off retail price[4] | $125 discount off retail price[4] | $125 discount off retail price[4] | Not covered |
| Contacts | $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), (ig), and (iii), see the Definitions section on page 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Gold[ic]<br>1,600/0%/HSA/Vision** | **KP MD Gold Added Choice[id]<br>1,000/100 RxDed/20/POS** | | **KP MD Gold<br>Virtual Complete 2,000** |
|---|---|---|---|---|
| | | **In-Network** | **Out-of-Network** | |
| Individual plan annual deductible (subscriber only) | $1,600 | $1,000 | $2,000 | $2,000 |
| Family plan annual deductible (individual/family) | N/A (individual)/$3,200 | $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) | $5,200 | $7,750 | $9,000 | $5,800 |
| Family plan annual out-of-pocket maximum (individual/family) | $5,200/$10,400 | $7,750/$15,500 | $9,000/$18,000 | $5,800/$11,600 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature or Select | Not applicable | S Signature only |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | |
| **Outpatient Services** | | | | |
| Primary care office visit | 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/<br>Lab $50 |
| MRI/CT/PET | No charge after deductible | $300 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<br>$10 group therapy | $45 individual therapy<br>$30 group therapy<br>(after deductible) | $20 for the first three visits, then $20 individual therapy (after deductible)<br>$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) | $200 per admission after deductible | $500 per admission after deductible | 20% after deductible | 20% after deductible |

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Gold(ic)**<br>**1,600/0%/HSA/Vision** | KP<br>**KP MD Gold Added Choice(id)**<br>**1,000/100 RxDed/20/POS** | | S<br>**KP MD Gold**<br>**Virtual Complete 2,000** |
|---|---|---|---|---|
| | | **In-Network** | **Out-of-Network** | |
| **Prescription Drugs (30-day supply)** | | | | |
| Rx–deductible | Medical deductible applies | $100 | 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 | $50 after Rx deductible | 20% after deductible | 20% after deductible |
| Rx–non-preferred brand drugs (Tier 3) | $65 after deductible | $100 after Rx deductible | 20% after deductible | 20% after deductible |
| Rx–specialty drugs (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 | $350 after deductible (waived if admitted) | $350 after deductible (waived if admitted) | $350 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)s[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 27.

[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Gold Flexible Choice[ie] 0/300 RxDed/20** | | |
|---|---|---|---|
| | **Option 1[1]** | **Option 2[1]** | **Option 3[1]** |
| Individual plan annual deductible (subscriber only) | None | $1,000 | $4,000 |
| Family plan annual deductible (individual/family) | None/None | $1,000/$2,000 | $4,000/$8,000 |
| Individual plan annual out-of-pocket maximum (subscriber only) | $4,450 | $4,650 | $9,100 |
| Family plan annual out-of-pocket maximum (individual/family) | $4,450/$8,900 | $4,650/$9,300 | $9,100/$18,200 |
| Network[iii] | KP Signature only | MultiPlan® and/or PHCS™, Cigna Healthcare℠ PPO | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | |
| **Outpatient Services** | | | |
| Primary care office visit | $20 | $35 | 20% after deductible |
| Specialty care office visit | $40 | $55 | 20% after deductible |
| Preventive care/screening/immunization | No charge | No charge | 20% after deductible |
| X-ray and lab diagnostic services | X-ray $40/Lab $25 | X-ray $60/Lab $45 | 20% after deductible |
| MRI/CT/PET | $350 | $400 after deductible | 20% after deductible |
| Telehealth | No charge | $35 primary care physician/$55 specialist | 20% after deductible |
| Outpatient facility fee | $275 | $325 after deductible | 20% after deductible |
| Mental health/chemical dependency outpatient services | $20 individual therapy<br>$10 group therapy | $35 individual therapy<br>$17 group therapy | 20% after deductible |
| **Maternity Services** | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | 20% after deductible |
| **Inpatient Services** | | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $550 per admission | $600 per admission after deductible | 20% after deductible |

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS** Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Gold Flexible Choice[ie] 0/300 RxDed/20** | | |
|---|---|---|---|
| | **Option 1[1]** | **Option 2[1]** | **Option 3[1]** |
| **Prescription Drugs (30-day supply)** | | | |
| Rx–deductible | $300 | $300 | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $25 | $45 | 20% after deductible |
| Rx–preferred brand drugs (Tier 2) | $60 after Rx deductible | $80 after Rx deductible | 20% after deductible |
| Rx–non-preferred brand drugs (Tier 3) | $80 after Rx deductible | $100 after Rx deductible | 20% after deductible |
| Rx–specialty drugs (Tier 4) | 50% up to $150 after Rx deductible | 50% up to $150 after Rx deductible | 50% up to $150 after deductible |
| **Urgent Care and Emergency Services** | | | |
| Urgent care centers (after-hours urgent care) | $40 | $55 | 20% after deductible |
| Emergency room | $350 (waived if admitted) | Covered in Option 1 | Covered in Option 1 |
| **Therapy and Rehabilitation Services** | | | |
| Habilitative and rehabilitative services | $40 | $60 | 20% after deductible |
| **Pediatric Dental Services** | | | |
| Periodic oral evaluation | $0[2] | Not covered | Not covered |
| Prophylaxis (cleaning) | $0[2] | Not covered | Not covered |
| Topical application of fluoride | $0[2] | Not covered | Not covered |
| Bitewing X-rays | $0 (no additional cost for 1 to 4 films)[2] | Not covered | Not covered |
| **Pediatric Vision Services** | | | |
| Routine eye exam with optometrist | $20 | $35 | 20% after deductible |
| Frames | No charge[3] | Not available | 40% after deductible |
| Lenses | No charge[3] | Not available | 40% after deductible |
| Contacts | No charge[4] | Not available | 40% after deductible |
| **Adult Vision Services** | | | |
| Routine eye exam with optometrist | $20 | $35 | 20% after deductible |
| Frames | $125 discount off retail[5] | Not available | 40% up to $100 after deductible |
| Lenses | $125 discount off retail[5] | Not available | 40% up to $150 after deductible |
| Contacts | $125 discount off retail[5] | Not available | 40% up to $50 after deductible |

For details about (ie) and (iii), see the Definitions section on page 27.
[1]Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).
[2]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[3]One pair per year from a selected group of frames.
[4]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.
[5]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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* and KPIC *Group Policy* and *Certificate of Insurance* for the complete list of services that are applied to the out-of-pocket maximum.

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS** Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Gold Flexible Choice[ie] 1,000/200 RxDed/20** | | |
|---|---|---|---|
| | **Option 1[1]** | **Option 2[1]** | **Option 3[1]** |
| Individual plan annual deductible (subscriber only) | $1,000 | $1,500 | $4,000 |
| Family plan annual deductible (individual/family) | $1,000/$2,000 | $1,500/$3,000 | $4,000/$8,000 |
| Individual plan annual out-of-pocket maximum (subscriber only) | $4,450 | $4,650 | $9,100 |
| Family plan annual out-of-pocket maximum (individual/family) | $4,450/$8,900 | $4,650/$9,300 | $9,100/$18,200 |
| Network[iii] | KP Signature only | MultiPlan® and/or PHCS™, Cigna Healthcare℠ PPO | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | |
| **Outpatient Services** | | | |
| Primary care office visit | $20 | $35 | 20% after deductible |
| Specialty care office visit | $40 | $55 | 20% after deductible |
| Preventive care/screening/immunization | No charge | No charge | 20% after deductible |
| X-ray and lab diagnostic services | X-ray $40/Lab $25 | X-ray $60/Lab $45 | 20% after deductible |
| MRI/CT/PET | $350 after deductible | $400 after deductible | 20% after deductible |
| Telehealth | No charge | $35 primary care physician/$55 specialist | 20% after deductible |
| Outpatient facility fee | $275 after deductible | $325 after deductible | 20% after deductible |
| Mental health/chemical dependency outpatient services | $20 individual therapy<br>$10 group therapy | $35 individual therapy<br>$17 group therapy | 20% after deductible |
| **Maternity Services** | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | 20% after deductible |
| **Inpatient Services** | | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $550 per admission after deductible | $600 per admission after deductible | 20% after deductible |
| **Prescription Drugs (30-day supply)** | | | |
| Rx–deductible | $200 | $250 | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $25 | $45 | 20% after deductible |
| Rx–preferred brand drugs (Tier 2) | $50 after Rx deductible | $80 after Rx deductible | 20% after deductible |
| Rx–non-preferred brand drugs (Tier 3) | $80 after Rx deductible | $100 after Rx deductible | 20% after deductible |
| Rx–specialty drugs (Tier 4) | 50% up to $150 after Rx deductible | 50% up to $150 after Rx deductible | 50% up to $150 after deductible |

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP<br>**KP MD Gold Flexible Choice[ie]**<br>**1,000/200 RxDed/20** | | |
|---|---|---|---|
| | **Option 1[1]** | **Option 2[1]** | **Option 3[1]** |
| **Urgent Care and Emergency Services** | | | |
| Urgent care centers (after-hours urgent care) | $40 | $55 | 20% after deductible |
| Emergency room | $350 after deductible | Covered in Option 1 | Covered in Option 1 |
| **Therapy and Rehabilitation Services** | | | |
| Habilitative and rehabilitative services | $40 | $60 | 20% after deductible |
| **Pediatric Dental Services** | | | |
| Periodic oral evaluation | $0[2] | Not covered | Not covered |
| Prophylaxis (cleaning) | $0[2] | Not covered | Not covered |
| Topical application of fluoride | $0[2] | Not covered | Not covered |
| Bitewing X-rays | $0 (no additional cost for 1 to 4 films)[2] | Not covered | Not covered |
| **Pediatric Vision Services** | | | |
| Routine eye exam with optometrist | $20 | $35 | 20% after deductible |
| Frames | No charge[3] | Not available | 40% after deductible |
| Lenses | No charge[3] | Not available | 40% after deductible |
| Contacts | No charge[4] | Not available | 40% after deductible |
| **Adult Vision Services** | | | |
| Routine eye exam with optometrist | $20 | $35 | 20% after deductible |
| Frames | $125 discount off retail price[5] | Not available | 40% up to $100 after deductible |
| Lenses | $125 discount off retail price[5] | Not available | 40% up to $150 after deductible |
| Contacts | $125 discount off retail price[5] | Not available | 40% up to $50 after deductible |

For details about (ie) and (iii), see the Definitions section on page 27.

[1]Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).

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

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

[4]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.

[5]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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* and KPIC *Group Policy* and *Certificate of Insurance* for the complete list of services that are applied to the out-of-pocket maximum.

## GOLD PLAN SUMMARIES (Cont.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Gold Flexible Choice[if] 1,600/0/HSA/Vision[1]** | | |
|---|---|---|---|
| | **Option 1[2]** | **Option 2[2]** | **Option 3[2]** |
| Individual plan annual deductible (subscriber only) | $1,600 | $3,200 | $4,500 |
| Family plan annual deductible (individual/family) | N/A (individual)/$3,200 | $3,200/$5,000 | $4,500/$9,000 |
| Individual plan annual out-of-pocket maximum (subscriber only) | $3,400 | $4,000 | $8,050 |
| Family plan annual out-of-pocket maximum (individual/family) | $3,400/$6,800 | $4,000/$8,000 | $8,050/$16,100 |
| Network[iii] | KP Signature only | MultiPlan® and/or PHCS™, Cigna Healthcare℠ PPO | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | |
| **Outpatient Services** | | | |
| Primary care office visit | No charge after deductible | $10 after deductible | 20% after deductible |
| Specialty care office visit | $20 after deductible | $30 after deductible | 20% after deductible |
| Preventive care/screening/immunization | No charge | No charge | 20% after deductible |
| X-ray and lab diagnostic services | X-ray $20/Lab no charge (after deductible) | X-ray $30/Lab $10 (after deductible) | 20% after deductible |
| MRI/CT/PET | $100 after deductible | $150 after deductible | 20% after deductible |
| Telehealth | No charge after deductible | $10 primary care physician/$30 specialist (after deductible) | 20% after deductible |
| Outpatient facility fee | $100 after deductible | $150 after deductible | 20% after deductible |
| Mental health/chemical dependency outpatient services | No charge individual therapy<br>No charge group therapy (after deductible) | $10 individual therapy<br>$5 group therapy (after deductible) | 20% after deductible |
| **Maternity Services** | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | 20% after deductible |
| **Inpatient Services** | | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $200 per admission after deductible | $250 per admission after deductible | 20% after deductible |
| **Prescription Drugs (30-day supply)** | | | |
| Rx–deductible | Medical deductible applies | Medical deductible applies | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $10 after deductible | $20 after deductible | 20% after deductible |
| Rx–preferred brand drugs (Tier 2) | $30 after deductible | $45 after deductible | 20% after deductible |
| Rx–non-preferred brand drugs (Tier 3) | $50 after deductible | $65 after deductible | 20% after deductible |
| Rx–specialty drugs (Tier 4) | 50% up to $150 after deductible | 50% up to $150 after deductible | 50% up to $150 after deductible |

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP MD Gold Flexible Choice(if) 1,600/0/HSA/Vision[1] | | |
|---|---|---|---|
| | **Option 1[2]** | **Option 2[2]** | **Option 3[2]** |
| **Urgent Care and Emergency Services** | | | |
| Urgent care centers (after-hours urgent care) | $20 after deductible | $30 after deductible | 20% after deductible |
| Emergency room | $350 after deductible (waived if admitted) | Covered in Option 1 | Covered in Option 1 |
| **Therapy and Rehabilitation Services** | | | |
| Habilitative and rehabilitative services | $20 after deductible | $30 after deductible | 20% after deductible |
| **Pediatric and Cosmetic Dental Services** | | | |
| Periodic oral evaluation | $0[3] | Not covered | Not covered |
| Prophylaxis (cleaning) | $0[3] | Not covered | Not covered |
| Topical application of fluoride | $0[3] | Not covered | Not covered |
| Bitewing X-rays | $0 (no additional cost for 1 to 4 films)[3] | Not covered | Not covered |
| **Pediatric Vision Services** | | | |
| Routine eye exam with optometrist | No charge after deductible | $10 after deductible | 20% after deductible |
| Frames | No charge after deductible[4] | Not available | 40% after deductible |
| Lenses | No charge after deductible[4] | Not available | 40% after deductible |
| Contacts | No charge after deductible[5] | Not available | 40% after deductible |
| **Adult Vision Services** | | | |
| Routine eye exam with optometrist | No charge after deductible | $10 after deductible | 20% after deductible |
| Frames | Not covered | Not covered | Not covered |
| Lenses | Not covered | Not covered | Not covered |
| Contacts | Not covered | Not covered | Not covered |

For details about (if) and (iii), see the Definitions section on page 27.

[1]Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the in-network tier (Option 1) and KPIC, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the out-of-network coverage consisting of the participating provider tier (Option 2) and the non-participating provider tier (Option 3) of the POS plan.
[2]Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).
[3]For more information and to obtain a copy of the applicable fee schedule, please visit **kp.org/dental/mas**.
[4]One pair per year from a selected group of frames.
[5]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.

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

## 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)*.

KP Offered through Kaiser Permanente  S Offered through Small Business Options Program (SHOP), Maryland Health Connection

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Silver[ia]<br>1,800/350 RxDed/40/Vision** | KP<br>**KP MD Silver Plus[ig]<br>1,800/350 RxDed/40/Vision** | | KP S<br>**KP MD Silver[ia]<br>2,500/40/Vision** |
|---|---|---|---|---|
| | | **Kaiser Permanente Providers** | **Out-of-Network Providers** | |
| Individual plan annual deductible (subscriber only) | $1,800 | $1,800 | Not applicable | $2,500 |
| Family plan annual deductible (individual/family) | $1,800/$3,600 | $1,800/$3,600 | 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) | $9,100 | $9,100 | Not applicable | $9,100 |
| Family plan annual out-of-pocket maximum (individual/family) | $9,100/$18,200 | $9,100/$18,200 | Not applicable | $9,100/$18,200 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature only | Not applicable | KP Signature or Select<br>S Signature only |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | |
| **Outpatient Services** | | | | |
| Primary care office visit | $40 | $40 | $60 (applies to 10-visit limit) | $40 |
| Specialty care office visit | $50 after deductible | $50 after deductible | $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 | X-ray $50/Lab $40 (after deductible) | X-ray $50/Lab $40 (after deductible) | X-ray $70/Lab $60 (applies to 10-visit limit) | $50 |
| 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<br>$20 group therapy | $40 individual therapy<br>$20 group therapy | $60 individual therapy<br>$30 group therapy<br>(applies to 10-visit limit) | $40 individual therapy<br>$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**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | **KP MD Silver[ia] 1,800/350 RxDed/40/Vision** | **KP MD Silver Plus[ig] 1,800/350 RxDed/40/Vision** | | **KP MD Silver[ia] 2,500/40/Vision** |
|---|---|---|---|---|
| | | **Kaiser Permanente Providers** | **Out-of-Network Providers** | |
| **Prescription Drugs (30-day supply)** | | | | |
| Rx–deductible | $350 | $350 | Not applicable | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $20 | $20 | $40 (each fill/refill applies to the 5-prescription limit) | $25 |
| 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 | $50 |
| Emergency room | $500 after deductible (waived if admitted) | $500 after deductible (waived if admitted) | $500 after deductible (waived if admitted) | $450 after deductible (waived if admitted) |
| **Therapy and Rehabilitation Services** | | | | |
| Habilitative and rehabilitative services | $50 after deductible | $50 after deductible | $70 (applies to 10-visit limit) | $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 | $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), (ig), and (iii), see the Definitions section on page 27.

[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## SILVER PLAN SUMMARIES (CONT.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S KP MD Silver[ic] 2,000/30/ HSA/Vision | KP MD Silver[ic] 3,000/30/ HSA/Vision | KP MD Silver[ic] 4,000/0/HSA/ Vision | KP MD Silver Added Choice[id] 2,500/40/POS/Vision | | KP MD Silver Virtual Forward 3,000 |
|---|---|---|---|---|---|---|
| | | | | In-Network | Out-of-Network | |
| Individual plan annual deductible (subscriber only) | $2,000 | $3,000 | $4,000 | $2,500 | $4,500 | $3,000 |
| Family plan annual deductible (individual/family) | N/A (individual)/ $4,000 | N/A (individual)/ $6,000 | $4,000/$8,000 | $2,500/$5,000 | $4,500/$9,000 | $3,000/$6,000 |
| Member coinsurance (plan pays/member pays), except as otherwise indicated | 100%/0% | 100%/0% | 100%/0% | 100%/0% | 70%/30% | 100%/0% |
| Individual plan annual out-of-pocket maximum (subscriber only) | $7,550 | $7,550 | $7,550 | $9,100 | $13,600 | $8,950 |
| Family plan annual out-of-pocket maximum (individual/family) | $7,550/$15,100 | $7,550/$15,100 | $7,550/$15,100 | $9,100/$18,200 | $13,600/$27,200 | $8,950/$17,900 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature or Select | KP Signature or Select | KP Signature or Select | Not applicable | KP Signature only |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | | | | |
| **Outpatient Services** | | | | | | |
| Primary care office visit | $30 after deductible | $30 after deductible | No charge after deductible | $40 | $70 | No charge for the first visit, then $40 after deductible |
| Specialty care office visit | $40 after deductible | $50 after deductible | $50 after deductible | $50 | $120 | $50 after deductible |
| Preventive care/screening/immunization | No charge | No charge | No charge | No charge | No charge after deductible | No charge |
| X-ray and lab diagnostic services | $40 (after deductible) | $50 (after deductible) | No charge after deductible | $50 | 30% after deductible | $50 after deductible |
| MRI/CT/PET | $400 after deductible | $400 after deductible | No charge after deductible | $400 after deductible | 30% after deductible | $400 after deductible |
| Telehealth | No charge after deductible | 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 | $250 after deductible | $250 after deductible | $250 after deductible | $350 after deductible | 30% after deductible | $300 after deductible |
| Mental health/chemical dependency outpatient services | $30 individual therapy<br>$15 group therapy (after deductible) | $30 individual therapy<br>$15 group therapy (after deductible) | No charge after deductible | $40 individual therapy<br>$20 group therapy | $70 individual therapy<br>$35 group therapy | No charge for the first visit, then $40 individual therapy after deductible;<br>$20 group therapy after deductible |

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S **KP MD Silver[ic] 2,000/30/ HSA/Vision** | KP **KP MD Silver[ic] 3,000/30/ HSA/Vision** | KP **KP MD Silver[ic] 4,000/0/HSA/ Vision** | KP **KP MD Silver Added Choice[id] 2,500/40/POS/Vision** | | KP **KP MD Silver Virtual Forward 3,000** |
|---|---|---|---|---|---|---|
| | | | | **In-Network** | **Out-of-Network** | |
| **Maternity Services** | | | | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | 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 admission after deductible | $500 per admission after deductible | $500 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 | Medical deductible applies | Medical deductible applies | Medical deductible applies | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $20 after deductible | $20 after deductible | $20 after deductible | $25 | 30% after deductible | $20 after deductible |
| Rx–preferred brand drugs (Tier 2) | $50 after deductible | $50 after deductible | $50 after deductible | $50 after Rx deductible | 30% after deductible | $50 after deductible |
| Rx–non-preferred brand drugs (Tier 3) | 50% after deductible | 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 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 | $50 after deductible | $50 after deductible | $50 | $120 | $50 after deductible |
| Emergency room | $400 after deductible (waived if admitted) | $400 after deductible (waived if admitted) | $350 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 | $50 after deductible | $50 after deductible | $50 after deductible | $85 after deductible | $50 after deductible |
| **Pediatric Dental Services** | | | | | | |
| Periodic oral evaluation | $0[1] | $0[1] | $0[1] | $0[1] | Not covered | $0[1] |
| Prophylaxis (cleaning) | $0[1] | $0[1] | $0[1] | $0[1] | Not covered | $0[1] |
| Topical application of fluoride | $0[1] | $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] | $0 (No additional cost for 1 to 4 films)[1] | Not covered | $0 (no additional cost for 1 to 4 films)[1] |

## SILVER PLAN SUMMARIES (CONT.)

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S **KP MD Silver[ic] 2,000/30/ HSA/Vision** | KP **KP MD Silver[ic] 3,000/30/ HSA/Vision** | KP **KP MD Silver[ic] 4,000/0/HSA/ Vision** | KP **KP MD Silver Added Choice[id] 2,500/40/POS/Vision** | | KP **KP MD Silver Virtual Forward 3,000** |
|---|---|---|---|---|---|---|
| | | | | **In-Network** | **Out-of-Network** | |
| **Pediatric Vision Services** | | | | | | |
| Routine eye exam with optometrist | $30 after deductible | $30 after deductible | No charge 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 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 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 after deductible[3] | No charge[3] | 40% after deductible[2] | No charge[3] |
| **Adult Vision Services** | | | | | | |
| Routine eye exam with optometrist | $30 after deductible | $30 after deductible | No charge after deductible | $40 | $70 | No charge for the first visit, then $40 after deductible |
| Frames | Not covered | Not covered | Not covered | $125 discount off retail price[4] | 10% discount off retail price | $125 discount off retail price |
| Lenses | Not covered | Not covered | Not covered | $125 discount off retail price[4] | 10% discount off retail price | $125 discount off retail price |
| Contacts | Not covered | Not covered | 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 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP **KP MD Silver[ia] 4,000/400 RxDed/40/Vision** | KP **KP MD Silver Plus[ig] 4,000/400 RxDed/40/Vision** | |
|---|---|---|---|
| | | **Kaiser Permanente Providers** | **Out-of-Network Providers** |
| Individual plan annual deductible (subscriber only) | $4,000 | $4,000 | Not applicable |
| Family plan annual deductible (individual/family) | $4,000/$8,000 | $4,000/$8,000 | Not applicable |
| Member coinsurance (plan pays/member pays), except as otherwise indicated | 100%/0% | 100%/0% | Not applicable |
| Individual plan annual out-of-pocket maximum (subscriber only) | $9,100 | $9,100 | Not applicable |
| Family plan annual out-of-pocket maximum (individual/family) | $9,100/$18,200 | $9,100/$18,200 | Not applicable |
| Network[iii] | KP Signature only | KP Signature only | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | |
| **Outpatient Services** | | | |
| Primary care office visit | $40 | $40 | $60 (applies to 10-visit limit) |
| Specialty care office visit | $50 | $50 | $70 (applies to 10-visit limit) |
| Preventive care/screening/immunization | No charge | No charge | No charge (applies to 10-visit limit) |
| X-ray and lab diagnostic services | $50 after deductible | $50 after deductible | $70 (applies to 10-visit limit) |
| MRI/CT/PET | $400 after deductible | $400 after deductible | Not covered |
| Telehealth | No charge | No charge | $60 (applies to 10-visit limit) |
| Outpatient facility fee | $350 after deductible | $350 after deductible | Not covered |
| Mental health/chemical dependency outpatient services | $40 individual therapy<br>$20 group therapy | $40 individual therapy<br>$20 group therapy | $60 individual therapy<br>$30 group therapy<br>(applies to 10-visit limit) |
| **Maternity Services** | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | Not covered |
| **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 |

## SILVER PLAN SUMMARIES (CONT.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP MD Silver[ia]<br>4,000/400 RxDed/40/Vision | KP MD Silver Plus[ig]<br>4,000/400 RxDed/40/Vision | |
|---|---|---|---|
| | | Kaiser Permanente Providers | Out-of-Network Providers |
| **Prescription Drugs (30-day supply)** | | | |
| Rx–deductible | $400 | $400 | Not applicable |
| Rx–generic drugs (Tier 1) | $20 | $20 | $40 (each fill/refill applies to the 5-prescription limit) |
| Rx–preferred brand drugs (Tier 2) | $50 after Rx deductible | $50 after Rx deductible | $70 (each fill/refill applies to the 5-prescription limit) |
| 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) |
| 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) |
| **Urgent Care and Emergency Services** | | | |
| Urgent care centers (after-hours urgent care) | $50 | $50 | $50 |
| Emergency room | $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 | $50 after deductible | $50 after deductible | $70 (applies to 10-visit limit) |
| **Pediatric Dental Services** | | | |
| Periodic oral evaluation | $0[1] | $0[1] | Not covered |
| Prophylaxis (cleaning) | $0[1] | $0[1] | Not covered |
| Topical application of fluoride | $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] | Not covered |
| **Pediatric Vision Services** | | | |
| Routine eye exam with optometrist | $40 | $40 | Not covered |
| Frames | No charge[2] | No charge[2] | Not covered |
| Lenses | No charge[2] | No charge[2] | Not covered |
| Contacts | No charge[3] | No charge[3] | Not covered |
| **Adult Vision Services** | | | |
| Routine eye exam with optometrist | $40 | $40 | Not covered |
| Frames | $125 discount off retail price[4] | $125 discount off retail price[4] | Not covered |
| Lenses | $125 discount off retail price[4] | $125 discount off retail price[4] | Not covered |
| Contacts | $125 discount off retail price[4] | $125 discount off retail price[4] | Not covered |

For details about (ic), (id), and (iii), see the Definitions section on page 27.

[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## 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)*.

KP Offered through Kaiser Permanente  S Offered through Small Business Options Program (SHOP), Maryland Health Connection

| **PLAN DETAILS**<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>**KP MD Bronze[ia] 6,500/50/Vision** | KP S<br>**KP MD Bronze[ic] 6,150/30/HSA/Vision** | KP S<br>**KP MD Bronze[ic] 7,050/0%/HSA/Vision** |
|---|---|---|---|
| Individual plan annual deductible (subscriber only) | $6,500 | $6,150 | $7,050 |
| Family plan annual deductible (individual/family) | $6,500/$13,000 | $6,150/$12,300 | $7,050/$14,100 |
| Member coinsurance (plan pays/member pays), except as otherwise indicated | 100%/0% | 100%/0% | 100%/0% |
| Individual plan annual out-of-pocket maximum (subscriber only) | $9,100 | $7,200 | $7,050 |
| Family plan annual out-of-pocket maximum (individual/family) | $9,100/$18,200 | $7,200/$14,400 | $7,050/$14,100 |
| Network[iii] | KP Signature or Select<br>S Signature only | KP Signature or Select<br>S Signature only | KP Signature or Select<br>S Signature only |
| HSA/HRA employer-required contribution | Not applicable | Not applicable | Not applicable |
| **BENEFITS** | | | |
| **Outpatient Services** | | | |
| Primary care office visit | $50 | $30 after deductible | No charge after deductible |
| Specialty care office visit | $80 | $50 after deductible | No charge after deductible |
| Preventive care/screening/immunization | No charge | No charge | No charge |
| X-ray and lab diagnostic services | X-ray $150/Lab $80 (after deductible) | X-ray $50/Lab $30 (after deductible) | No charge after deductible |
| MRI/CT/PET | $500 after deductible | $400 after deductible | No charge after deductible |
| Telehealth | No charge | No charge after deductible | No charge after deductible |
| Outpatient facility fee | $400 after deductible | $300 after deductible | No charge after deductible |
| Mental health/chemical dependency outpatient | $50 individual therapy<br>$25 group therapy | $30 individual therapy<br>$15 group therapy (after deductible) | No charge after deductible |
| **Maternity Services** | | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | No charge | No charge |
| **Inpatient Services** | | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $600 per day up to 3 days per admission after deductible | $500 per admission after deductible | No charge after deductible |

## BRONZE PLAN SUMMARIES (CONT.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP S<br>KP MD Bronze[ia]<br>6,500/50/Vision | KP S<br>KP MD Bronze[ic]<br>6,150/30/HSA/Vision | KP S<br>KP MD Bronze[ic]<br>7,050/0%/HSA/Vision |
|---|---|---|---|
| **Prescription Drugs (30-day supply)** | | | |
| Rx–deductible | Medical deductible applies | Medical deductible applies | Medical deductible applies |
| Rx–generic drugs (Tier 1) | $30 | $10 after deductible | No charge after deductible |
| Rx–preferred brand drugs (Tier 2) | $120 after deductible | $40 after deductible | No charge after deductible |
| Rx–non-preferred brand drugs (Tier 3) | 50% after deductible | $75 after deductible | No charge after deductible |
| Rx–specialty drugs (Tier 4) | 50% up to $150 after deductible | 50% up to $150 after deductible | No charge after deductible |
| **Urgent Care and Emergency Services** | | | |
| Urgent care centers (after-hours urgent care) | $80 | $50 after deductible | No charge after deductible |
| Emergency room | $600 after deductible (waived if admitted) | $250 after deductible (waived if admitted) | No charge after deductible |
| **Therapy and Rehabilitation Services** | | | |
| Habilitative and rehabilitative services | $80 after deductible | $50 after deductible | No charge after deductible |
| **Pediatric Dental Services** | | | |
| Periodic oral evaluation | $0[1] | $0[1] | $0[1] |
| Prophylaxis (cleaning) | $0[1] | $0[1] | $0[1] |
| Topical application of fluoride | $0[1] | $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] | $0 (no additional cost for 1 to 4 films)[1] |
| **Pediatric Vision Services** | | | |
| Routine eye exam with optometrist | $50 | $30 after deductible | No charge after deductible |
| Frames | No charge[2] | No charge after deductible[2] | No charge after deductible[2] |
| Lenses | No charge[2] | No charge after deductible[2] | No charge after deductible[2] |
| Contacts | No charge[3] | No charge after deductible[3] | No charge after deductible[3] |
| **Adult Vision Services** | | | |
| Routine eye exam with optometrist | $50 | $30 after deductible | No charge after deductible |
| Frames | $125 discount off retail price[4] | Not covered | Not covered |
| Lenses | $125 discount off retail price[4] | Not covered | Not covered |
| Contacts | $125 discount off retail price[4] | Not covered | Not covered |

For details about (ic), (id), and (iii), see the Definitions section on page 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## BRONZE PLAN SUMMARIES (CONT.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP MD Bronze Plus[ig] 6,500/50/Vision | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| Individual plan annual deductible (subscriber only) | $6,500 | Not applicable |
| Family plan annual deductible (individual/family) | $6,500/$13,000 | Not applicable |
| Member coinsurance (plan pays/member pays), except as otherwise indicated | 100%/0% | Not applicable |
| Individual plan annual out-of-pocket maximum (subscriber only) | $9,100 | Not applicable |
| Family plan annual out-of-pocket maximum (individual/family) | $9,100/$18,200 | Not applicable |
| Network[iii] | KP Signature only | Not applicable |
| HSA/HRA employer-required contribution | Not applicable | Not applicable |
| **BENEFITS** | | |
| **Outpatient Services** | | |
| Primary care office visit | $50 | $70 (applies to 10-visit limit) |
| Specialty care office visit | $80 | $100 (applies to 10-visit limit) |
| Preventive care/screening/immunization | No charge | No charge (applies to 10-visit limit) |
| X-ray and lab diagnostic services | X-ray $150/Lab $80 (after deductible) | X-ray $170/Lab $100 (applies to 10-visit limit) |
| MRI/CT/PET | $500 after deductible | Not covered |
| Telehealth | No charge | $70 (applies to 10-visit limit) |
| Outpatient facility fee | $400 after deductible | Not covered |
| Mental health/chemical dependency outpatient | $50 individual therapy/$25 group therapy | $70 individual therapy/$35 group therapy (applies to 10-visit limit) |
| **Maternity Services** | | |
| Routine prenatal visits (after confirmation of pregnancy) and postnatal visits | No charge | Not covered |
| **Inpatient Services** | | |
| All inpatient hospital services (applies to all inpatient hospital stays for any reason) | $600 per day up to 3 days per admission after deductible | Not covered |
| **Prescription Drugs (30-day supply)** | | |
| Rx–deductible | Medical deductible applies | Not applicable |
| Rx–generic drugs (Tier 1) | $30 | $50 (each fill/refill applies to the 5-prescription limit) |
| Rx–preferred brand drugs (Tier 2) | $120 after deductible | $140 (each fill/refill applies to the 5-prescription limit) |
| Rx–non-preferred brand drugs (Tier 3) | 50% after deductible | 60% (each fill/refill applies to the 5-prescription limit) |
| Rx–specialty drugs (Tier 4) | 50% up to $150 after deductible | 60% up to $150 (each fill/refill applies to the 5-prescription limit) |

## BRONZE PLAN SUMMARIES (CONT.)

| PLAN DETAILS<br>Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information. | KP MD Bronze Plus[ig]<br>6,500/50/Vision | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Urgent Care and Emergency Services** | | |
| Urgent care centers (after-hours urgent care) | $80 | $80 |
| Emergency room | $600 after deductible (waived if admitted) | $600 after deductible (waived if admitted) |
| **Therapy and Rehabilitation Services** | | |
| Habilitative and rehabilitative services | $80 after deductible | $100 |
| **Pediatric Dental Services** | | |
| Periodic oral evaluation | $0[1] | Not covered |
| Prophylaxis (cleaning) | $0[1] | Not covered |
| Topical application of fluoride | $0[1] | Not covered |
| Bitewing X-rays | $0 (no additional cost for 1 to 4 films)[1] | Not covered |
| **Pediatric Vision Services** | | |
| Routine eye exam with optometrist | $50 | Not covered |
| Frames | No charge[2] | Not covered |
| Lenses | No charge[2] | Not covered |
| Contacts | No charge[3] | Not covered |
| **Adult Vision Services** | | |
| Routine eye exam with optometrist | $50 | Not covered |
| Frames | $125 discount off retail price[4] | Not covered |
| Lenses | $125 discount off retail price[4] | Not covered |
| Contacts | $125 discount off retail price[4] | Not covered |

For details about (ig) and (iii), see the Definitions section on page 27.
[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. This statement does not apply to out-of-network services or HSA-qualified plans. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

## 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) Deductible Flexible Choice Plans**
Deductible Flexible Choice plans allow members to receive care from: (1) Permanente physicians in the Mid-Atlantic Permanente Medical Group, P.C. (HMO); (2) from physicians in the PHCS™ or MultiPlan® networks when getting care in a Kaiser Permanente service area,[1] or from the Cigna Healthcare℠ PPO Network when getting care outside a Kaiser Permanente service area; and (3) out-of-network from any other licensed provider. Benefit levels and cost shares vary according to the provider option. In general, the member's out-of-pocket costs may increase from HMO providers to PPO providers to out-of-network providers.

**(if) HSA-Qualified Flexible Choice Plans**
HSA-Qualified Flexible Choice plans can be paired with a health savings account (HSA), which allows members to set aside pretax dollars to pay for qualified medical expenses.

**(ig) Kaiser Permanente Plus Plans**
The 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).

**(iia) HSA-Qualified Deductible HMO Plans with Health Savings Accounts (HSA) or Health Reimbursement Arrangements (HRA)**
These plans require that the employer open and contribute to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) for employees. The contribution amounts are exact and defined by the plan.

**(iii) Kaiser Permanente Signature**
With the Kaiser Permanente Signature Delivery System, 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.

**(iii) PHCS™ and MultiPlan® Provider Networks**
Both participating provider networks for KPIC available in Option 2 of the Deductible Flexible Choice and HSA-Qualified Flexible Choice plans when getting care in a Kaiser Permanente service area.[1]

The PHCS™ and MultiPlan® networks include physicians and health care practitioners and facilities available to Flexible Choice members via Kaiser Permanente Insurance Company's network access agreement. Not all PHCS™ and MultiPlan® network providers are included. For a list of network providers, go to **multiplan.com/kpmas**.

**(iii) Cigna Healthcare℠ PPO Network Provider Network in Option 2 of the Flexible Choice plans when getting care outside of a Kaiser Permanente service area.**
The Cigna Healthcare℠ PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration. Cigna Healthcare is an independent company and not affiliated with Kaiser Permanente Insurance Company or Kaiser Foundation Health Plan. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with Kaiser Permanente Insurance Company and Kaiser Foundation Health Plan. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

[1]Kaiser Permanente service areas include all or parts of, GA, MD, HI, OR, VA, and DC.

## 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 serious complications of the non-covered Service.

For example, if you have a non-covered cosmetic surgery, we would 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 would cover any Services that we would otherwise cover to treat that complication.

The following services are excluded from coverage:

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Other services to the extent they are covered by any government unit, except for veterans in Veterans Administration or armed forces facilities for services received for which the recipient is liable.
5. Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. Except for the pediatric vision benefit in the **List of Benefits** in this section—the purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal Care Services and Domiciliary Care Services.
8. Services rendered by a Health Care Practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother or sister.
9. Experimental Services. This exclusion does not apply to Services covered under the clinical trials benefit in the **List of Benefits** in this section.
10. Practitioner, Hospital or clinical Services related to radial keratotomy, myopic keratomileusis and surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
11. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the **List of Benefits** in this section.
12. Services incurred before the effective date of coverage for a Covered Person.
13. Services incurred after a Covered Person's termination of coverage, except as provided in **Section 6: Extension of Benefits.**
14. 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.
15. Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a worker's compensation law.
16. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment.
18. Except for a covered telehealth consultation, charges for telephone consultations, failure to keep a scheduled visit or completion of any form.
19. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.
20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in the **List of Benefits** in this section.
21. Travel, whether or not it is recommended by a Health Care Practitioner, except for:
    a. Covered ambulance Services; and
    b. Air travel in connection with a covered transplant for the recipient and a companion or two companions if recipient is under age 18, to and from the site of a covered organ transplant.
22. Except for Emergency Services and Urgent Care Service, services received while the Covered Person is outside of the United States.
23. Immunizations related to foreign travel.
24. Unless otherwise specified in the **List of Benefits** in this section, or the Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix or the Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix; as applicable: Dental work or treatment which includes Hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures;
    b. Orthodontic care or malocclusion;
    c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident; and
    d. Dental implants.
25. Except as provided under the Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix or the Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix; as applicable: Accidents occurring while and as a result of chewing.
26. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting, unless these Services are deemed to be Medically Necessary.
27. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
28. Services to reverse voluntary, surgically induced infertility.
29. Treatment of sexual dysfunction not related to organic disease.
30. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
31. Non-human organs and their implantation.

32. Non-replacement fees for blood and blood products.
33. Lifestyle improvements or physical fitness programs, unless included in the **List of Benefits** in this section.
34. Wigs or cranial prosthesis, except for one (1) Medically Necessary hair prosthesis as noted above in the **List of Benefits** in this section.
35. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
36. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
37. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the Services are payable under a medical expense payment provision of an automobile insurance policy.
38. Services for conditions that state or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
39. Services for, or related to, the removal of an organ from a Covered Person for the purposes of transplantation into another person unless the:
    a. Transplant recipient is covered under the Health Plan and is undergoing a covered transplant; and
    b. Services are not payable by another carrier.
40. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
41. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
42. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
43. Private duty nursing, unless authorized by the Health Plan.
44. Any claim, bill or other demand or request for payment for health care Services determined to be furnished as a result of a referral prohibited by §1-302 of the Health Occupations Article.
45. Worker's Compensation or Employer Liability: Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a worker's compensation law.

## 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;
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 Covered Person in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some Covered Persons 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, he or she 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

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

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.

## PHARMACY LIMITATIONS

### Dispensing Limitations

Except for Maintenance Medications and contraceptive drugs as described below, Covered Persons may obtain up to a thirty (30)-day supply 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.

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.

Covered Persons may obtain a partial supply of a prescription drug and will be charged a prorated daily Copayment or Coinsurance, if the following conditions are met:

1. The prescriber determines dispensing a partial supply of a prescription drug to be in the best interest of the Covered Person;
2. The prescription drug is anticipated to be required for more than three (3) months;
3. The Covered Person requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Covered Person's prescription drugs;
4. The prescription drug is not a Schedule II controlled dangerous substance; and
5. The supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

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.

If a drug meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Covered Person's cost for the drug will not exceed $150 for a thirty (30)-day supply. For all insulin, the Covered Person's cost will not exceed $30 for a 30-day supply in accordance with §15-822.1 of the Insurance Article.

### Maintenance Medication Dispensing Limitations

Covered Persons 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 Manufacturer's Package Size; and
3. Specified dispensing limits.

### Contraceptive Drug Dispensing Limitations

For prescribed contraceptives, you may obtain up to a twelve (12)-month supply for a single dispense and at a Plan Pharmacy or through our Mail Service Delivery Program.

## DENTAL GENERAL EXCLUSIONS

The following services are not covered under this Dental Plan 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.

## KPIC EXCLUSIONS

Exclusions apply to Deductible Flexible Choice and HSA-qualified Flexible Choice plans only. Unless specifically stated otherwise in the *Group Policy* or elsewhere in this Certificate or in the Schedule of Coverage, no payment will be made under any benefit of the plan for Expenses Incurred in connection with the following:

1. Charges for services approved by or reimbursed by Health Plan.
2. Charges in excess of the Maximum Allowable Charge.
3. Confinement, treatment, services or supplies that are not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the plan.
4. Services performed or prescribed under the direction of a person who is not a heath care practitioner.
5. Services that are beyond the scope of practice of the health care practitioner performing the service.
6. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
7. Charges for services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
8. Charges for personal care services and domiciliary care services.
9. Charges for non-Emergency Care in an Emergency Care setting to the extent that they exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether services were rendered in connection with an emergency will rest solely with KPIC.
10. Weekend admission charges for non Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive and does not include admissions for maternity.
11. Treatment, services, or supplies provided by a health care practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother or sister.
12. Charges for experimental services.
13. Charges from a practitioner, hospital or for clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
14. Confinement, treatment, services or supplies received outside the United States, if such confinement, treatment, services or supplies are of the type and nature that are not available in the United States.
15. Injury or Sickness for which benefits are payable under any state or federal worker's compensation, employer's liability, or occupational disease or similar law.
16. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless worker's compensation or benefits under similar law are not required or available.
17. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
18. Services to reverse a voluntary sterilization procedure for an Adult or a Dependent minor.
19. Services for sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.
20. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the "Covered Services" section of this Certificate.
21. Services incurred before the effective date of coverage for a Covered Person.
22. Services incurred after a Covered Person's termination of coverage, except as provided in the Extension of Benefits provision.
23. Personal Care Services and Domiciliary Care Services.Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
24. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
25. Charges for telephone consultations except for services covered under Telehealth, failure to keep a scheduled visit, or completion of any form.
26. Inpatient admissions primarily for diagnostic studies, unless authorized by KPIC.
27. The purchase, examination, or fitting of hearings aids and supplies, and tinnitus maskers, unless otherwise specified under the "Covered Services" section of this Certificate.
28. Immunizations related to foreign travel.
29. Dental care and dental X-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, or medical condition, including surgery on the jawbone and radiation treatment. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment. This exclusion does not include visits for repairs or treatment of cleft lip, cleft palate or both. This exclusion also does not include: (1) surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part or (2) removable appliances for TMJ repositioning. In addition, this exclusion does not include visits for repairs or treatment of accidental injury to sound natural teeth when performed or rendered within six (6) months following the accident.
30. Routine foot care unless otherwise specified in the "Covered Services" section of this Certificate.
31. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.
32. Inpatient admissions primarily for physical therapy, unless authorized by KPIC.
33. Treatment of sexual dysfunction not related to organic disease.
34. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.
35. Non-human organs and their implantation.

36. Non-replacement fees for blood and blood products.

37. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included in the "Covered Services" section of this Certificate.

38. Outpatient orthomolecular therapy, including non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.

39. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

40. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

41. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

42. Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person.

43. Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

44. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

45. Private hospital room, unless authorized by KPIC.

46. Private duty nursing, unless authorized by KPIC.

47. Experimental Services. This exclusion does not apply to services covered under clinical trials in the "General Benefits" section.

48. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.

49. Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.

50. Services for which no charge is normally made in the absence of insurance.

51. Any claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral as determined by the appropriate regulatory board.

52. Adult vision hardware in HDHP/HSA plans.

53. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.

## PRESCRIPTION DRUG EXCLUSIONS

The following items are excluded from Outpatient Prescription Drug coverage:

1. Administration of a drug or medicine;

2. Any drug or medicine administered as Necessary Services and Supplies (See the General Definitions section.);

3. Drugs not approved by the FDA;

4. Drugs and injectables for the treatment of sexual dysfunction disorders regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation;

5. Drugs and injectables for the treatment of cosmetic services;

6. Replacement of lost or damaged drugs and accessories;

7. Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Covered Person's condition. In addition, this exclusion will not apply to routine patient care costs related to clinical trial if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has a meaningful potential to benefit the Covered Person. Additionally, this exclusion will not apply to off-label use of a FDA approved drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

8. Internally Implanted time-release drugs and medicines;

9. Drugs associated with non-covered services;

10. Infant formulas, except for amino acid-based elemental formulas and special food products to treat PKU as set forth as a limited benefit under the GENERAL BENEFITS section of this Certificate;

11. Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency.

12. Anorectic or any drug used for the purpose of weight loss or weight loss management unless prescribed in the treatment of morbid obesity, unless covered under the Preventive Services benefits as required by PPACA.

13. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician, unless covered under the preventive Services benefits as required by PPACA [ and, except as otherwise allowed for over-the-counter contraceptives asset forth under the Drugs Covered provision above].

14. Biotechnology drugs and diagnostic agents. The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome.

## 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**)።

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-225-7202** (TTY: **711**).

**Ɓăsɔ́ ɔ̀ 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 bɛ́ìn m̀ gbo kpáa. Ɖá **1-888-225-7202** (TTY: **711**)

**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**)

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St., Rockville, MD 20852
2023SG1267 MAS 9/30/23-12/31/24