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

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

TABLE OF CONTENTS

Virginia 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 the Small Business Health Options Program

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Platinum 0 Ded/Vision**	KP **KP VA Platinum Plus[if] 0 Ded/Vision**		KP S **KP VA Platinum[ia] 500 Ded/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)	$2,500	$2,500	Not applicable	$2,500
Family plan annual out-of-pocket maximum (individual/family)	$2,500/$5,000	$2,500/$5,000	Not applicable	$2,500/$5,000
Network[iii]	KP Signature or Select S Signature only	KP Signature only	Not applicable	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$15	$15	$35 (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 (applies to 10-visit limit)	No charge
X-rays and laboratory diagnostic services	$30	$30	$50 (applies to 10-visit limit)	$30
MRI/CT/PET	$200	$200	Not covered	$100 after deductible
Telehealth	No charge	No charge	$35 (applies to 10-visit limit)	No charge
Outpatient facility fee	$100	$100	Not covered	$100 after deductible
Mental health/chemical dependency outpatient	$15 individual therapy $7 group therapy	$15 individual therapy $7 group therapy	$35 individual therapy $17 group therapy (applies to 10-visit limit)	$20 individual therapy $10 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$150 per admission	$150 per admission	Not covered	$150 per admission after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Platinum 0 Ded/Vision**	**KP VA Platinum Plus(if) 0 Ded/Vision**		**KP VA Platinum(ia) 500 Ded/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 $300	50% up to $300	60% up to $300 (each fill/refill applies to the 5-prescription limit)	50% up to $300
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)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	No charge	No charge	Not covered	No charge
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	$15	$15	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), (if), and (iii), see the Definitions section on page 28.
[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 the Small Business Health Options Program

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Gold 0 Ded/Vision**	KP **KP VA Gold Plus[if] 0 Ded/Vision**		KP S **KP VA Gold[ia] 500 Ded/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)	$8,600	$8,600	Not applicable	$6,600
Family plan annual out-of-pocket maximum (individual/family)	$8,600/$17,200	$8,600/$17,200	Not applicable	$6,600/$13,200
Network[iii]	KP Signature or Select S Signature only	KP Signature only	Not applicable	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$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-rays and laboratory 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	$150	$150	Not covered	$250 after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$40 individual therapy $20 group therapy (applies to 10-visit limit)	$20 individual therapy $10 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per admission	$500 per admission	Not covered	$500 per admission after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP VA Gold 0 Ded/Vision	KP KP VA Gold Plus(if) 0 Ded/Vision		KP S KP VA Gold(ia) 500 Ded/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)	$20	$20	$40 (each fill/refill applies to the 5-prescription limit)	$20
Rx–preferred brand drugs (Tier 2)	$70	$70	$90 (each fill/refill applies to the 5-prescription limit)	$70
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 $300	50% up to $300	60% up to $300 (each fill/refill applies to the 5-prescription limit)	50% up to $300
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	No charge	No charge	Not covered	No charge
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), (if), and (iii), see the Definitions section on page 28.
[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 Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP S KP VA Gold[ia] 1,000 Ded/Vision**	**KP KP VA Gold[ib] 1,500 Ded/ 150 RxDed/Vision**	**KP KP VA Gold Plus[if] 1,500 Ded/150 RxDed/Vision**		**KP KP VA Gold Virtual Complete 2,000 Ded**
			Kaiser Permanente Providers	**Out-of-Network Providers**	
Individual plan annual deductible (subscriber only)	$1,000	$1,500	$1,500	Not applicable	$2,000
Family plan annual deductible (individual/family)	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000	Not applicable	$4,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	100%/0%	Not applicable	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$6,900	$6,350	$6,350	Not applicable	$5,000
Family plan annual out-of-pocket maximum (individual/family)	$6,900/$13,800	$6,350/$12,700	$6,350/$12,700	Not applicable	$5,000/$10,000
Network[iii]	KP Signature or Select S Signature only	KP Signature or Select	KP Signature only	Not applicable	KP Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit (copay waived for children under 5 years old)	$20	$20	$20	$40 (applies to 10-visit limit)	$20 for the first three visits, then $20 after deductible
Specialty care office visit	$50	$50	$50	$70 (applies to 10-visit limit)	$50 after deductible
Preventive care/screening/immunization	No charge	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-rays and laboratory diagnostic services	$50	$50	$50	$70 (applies to 10-visit limit)	X-rays 20% after deductible; lab $50
MRI/CT/PET	$300 after deductible	$300 after deductible	$300 after deductible	Not covered	20% after deductible
Telehealth	No charge	No charge	No charge	$40 (applies to 10-visit limit)	No charge
Outpatient facility fee	$250 after deductible	$250 after deductible	$250 after deductible	Not covered	20% after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$20 individual therapy $10 group therapy	$40 individual therapy $20 group therapy (applies to 10-visit limit)	$20 for the first three visits, then $20 individual therapy after deductible; $10 for the first three visits, then $10 group therapy after deductible
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	Not covered	No charge

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Gold[ia] 1,000 Ded/Vision**	KP **KP VA Gold[ib] 1,500 Ded/ 150 RxDed/Vision**	KP **KP VA Gold Plus[if] 1,500 Ded/150 RxDed/Vision**		KP **KP VA Gold Virtual Complete 2,000 Ded**
			Kaiser Permanente Providers	**Out-of-Network Providers**	
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	20% after deductible
Prescription Drugs (30-day supply)					
Rx–deductible	None	$150	$150	Not applicable	Medical deductible applies
Rx–generic drugs (Tier 1)	$20	$20	$20	$40 (each fill/refill applies to the 5-prescription limit)	$20
Rx–preferred brand drugs (Tier 2)	$70	$50 after Rx deductible	$50 after Rx deductible	$70 (each fill/refill applies to the 5-prescription limit)	20% after deductible
Rx–non-preferred brand drugs (Tier 3)	$100	$100 after Rx deductible	$100 after Rx deductible	$120 (each fill/refill applies to the 5-prescription limit)	20% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300	50% up to $300 after Rx deductible	50% up to $300 after Rx deductible	60% up to $300 (each fill/refill applies to the 5-prescription limit)	50% up to $300 after deductible
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	$50	$50	$50	$50	$50 after deductible
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)	20% after deductible
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	$50	$50	$50	$70 (applies to 10-visit limit)	$50 after deductible
Pediatric Dental Services					
Periodic oral evaluation	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services					
Routine eye exam with optometrist	No charge	No charge	No charge	Not covered	No charge
Frames	No charge[2]	No charge[2]	No charge[2]	Not covered	No charge[2]
Lenses	No charge[2]	No charge[2]	No charge[2]	Not covered	No charge[2]
Contacts	No charge[3]	No charge[3]	No charge[3]	Not covered	No charge[3]

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Gold[ia]** **1,000 Ded/Vision**	KP **KP VA Gold[ib]** **1,500 Ded/** **150 RxDed/Vision**	KP **KP VA Gold Plus[if]** **1,500 Ded/150 RxDed/Vision**		KP **KP VA Gold Virtual Complete 2,000 Ded**
			Kaiser Permanente Providers	**Out-of-Network Providers**	
Adult Vision Services					
Routine eye exam with optometrist	$20	$20	$20	Not covered	$20 for the first three visits, then $20 after deductible
Frames	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price
Lenses	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price
Contacts	$125 discount off retail price[4]	$125 discount off retail price[4]	$125 discount off retail price[4]	Not covered	$125 discount off retail price

For details about (ia), (ib), (if), and (iii), see the Definitions section on page 28.
[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 Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Gold[ic]** **1,600 Ded/HSA/Vision**	KP **KP VA Gold Added Choice[id]** **1,000 Ded/Vision**	
		In-Network	**Out-of-Network**
Individual plan annual deductible (subscriber only)	$1,600	$1,000	$3,500
Family plan annual deductible (individual/family)	N/A (individual)/$3,200	$1,000/$2,000	$3,500/$7,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$5,000	$6,900	$8,000
Family plan annual out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,900/$13,800	$8,000/$16,000
Network[iii]	KP Signature or Select S Signature only	KP Signature or Select	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit (copay waived for children under 5 years old)	No charge after deductible	$20	$45 after deductible
Specialty care office visit	No charge after deductible	$50	$55 after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible
X-rays and laboratory diagnostic services	No charge after deductible	$50	20% after deductible
MRI/CT/PET	No charge after deductible	$300 after deductible	20% after deductible
Telehealth	No charge after deductible	No charge	Applicable cost shares apply based on type of provider
Outpatient facility fee	$100 after deductible	$250 after deductible	20% after deductible
Mental health/chemical dependency outpatient services	No charge after deductible	$20 individual therapy/$10 group therapy	$45 individual therapy/$30 group therapy (after deductible)
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)	No charge after deductible	$500 per admission after deductible	20% after deductible
Prescription Drugs (30-day supply)			
Rx–deductible	Medical deductible applies	None	Medical deductible applies
Rx–generic drugs (Tier 1)	$20 after deductible	$20	20% after deductible
Rx–preferred brand drugs (Tier 2)	$50 after deductible	$70	20% after deductible
Rx–non-preferred brand drugs (Tier 3)	$75 after deductible	$100	20% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300 after deductible	50% up to $300	50% up to $300 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Gold[ic]** **1,600 Ded/HSA/Vision**	**KP VA Gold Added Choice[id]** **1,000 Ded/Vision**	
		In-Network	**Out-of-Network**
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	No charge after deductible	$50	$55 after deductible
Emergency room	$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	No charge after deductible	$50	$55 after deductible
Pediatric Dental Services			
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
Periodic oral evaluation	$0[2]	$0[2]	Not covered
Prophylaxis (cleaning)	$0[2]	$0[2]	Not covered
Topical application of fluoride	$0[2]	$0[2]	Not covered
Pediatric Vision Services			
Routine eye exam with optometrist	No charge after deductible	No charge	$45 after deductible
Frames	No charge after deductible[3]	No charge[3]	20% after deductible[3]
Lenses	No charge after deductible[3]	No charge[3]	20% after deductible[3]
Contacts	No charge after deductible[4]	No charge[4]	20% after deductible[4]
Adult Vision Services			
Routine eye exam with optometrist	No charge after deductible	$20	$45 after deductible
Frames	Not covered	$125 discount off retail price[5]	10% discount off retail price
Lenses	Not covered	$125 discount off retail price[5]	10% discount off retail price
Contacts	Not covered	$125 discount off retail price[5]	5% discount off retail price

For details about (ic), (id), (ie), and (iii), see the Definitions section on page 28.

[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.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Gold Flexible Choice[ie]** **0 Ded/300 RxDed[1]**		
	Option 1[2]	**Option 2[2]**	**Option 3[2]**
Individual plan annual deductible (subscriber only)	$0	$500	$4,000
Family plan annual deductible (individual/family)	$0/$0	$500/$1,000	$4,000/$8,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	60%/40%
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™, Cigno PPO	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit (copay waived for children under 5 years old)	$20	$30	40% after deductible
Specialty care office visit	$40	$55	40% after deductible
Preventive care/screening/immunization	No charge	No charge	40% after deductible
X-rays and laboratory diagnostic services	X-ray $40/Lab $25	X-ray $60/Lab $45	40% after deductible
MRI/CT/PET	$350	$400 after deductible	40% after deductible
Telehealth	No charge	$30 primary care physician/$55 specialist	40% after deductible
Outpatient facility fee	$275	$325 after deductible	40% after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy $10 group therapy	$30 individual therapy $15 group therapy	40% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	40% 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	40% after deductible
Prescription Drugs (30-day supply)			
Rx–deductible	$300	$300	Medical deductible applies
Rx–generic drugs (Tier 1)	$25	$45	50% after deductible
Rx–preferred brand drugs (Tier 2)	$60 after deductible	$80 after deductible	50% after deductible
Rx–non-preferred brand drugs (Tier 3)	$80 after deductible	$100 after deductible	50% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300 after Rx deductible	50% up to $300 after deductible	50% up to $300 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Gold Flexible Choice[ie]** **0 Ded/300 RxDed[1]**		
	Option 1[2]	**Option 2[2]**	**Option 3[2]**
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	$40	$55	40% after deductible
Emergency room	$350	Covered in Option 1	Covered in Option 1
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	$40	$60	40% after deductible
Pediatric Dental Services			
Periodic oral evaluation	$0[3]	Not applicable	Not applicable
Prophylaxis (cleaning)	$0[3]	Not applicable	Not applicable
Topical application of fluoride	$0[3]	Not applicable	Not applicable
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[2]	Not applicable	Not applicable
Pediatric Vision Services			
Routine eye exam with optometrist	No charge	$30	40% after deductible
Frames	No charge[4]	Not available	40% after deductible
Lenses	No charge[4]	Not available	40% after deductible
Contacts	No charge[5]	Not available	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	$20	$30	40% after deductible
Frames	$125 discount off retail price[6]	Not available	40% up to $100 after deductible
Lenses	$125 discount off retail price[6]	Not available	40% up to $150 after deductible
Contacts	$125 discount off retail price[6]	Not available	40% up to $50 after deductible

For details about (ie) and (iii), see the Definitions section on page 28.

[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.

[6]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. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP **KP VA Gold Flexible Choice[ie]** **500 Ded/300 RxDed**		
	Option 1[1]	**Option 2**[1]	**Option 3**[1]
Individual plan annual deductible (subscriber only)	$500	$1,000	$4,000
Family plan annual deductible (individual/family)	$500/$1,000	$1,000/$2,000	$4,000/$8,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	60%/40%
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 (copay waived for children under 5 years old)	$20	$30	40% after deductible
Specialty care office visit	$40	$55	40% after deductible
Preventive care/screening/immunization	No charge	No charge	40% after deductible
X-rays and laboratory diagnostic services	X-ray $40/Lab $25	X-ray $60/Lab $45	40% after deductible
MRI/CT/PET	$350 after deductible	$400 after deductible	40% after deductible
Telehealth	No charge	$30 primary care physician/$55 specialist	40% after deductible
Outpatient facility fee	$275 after deductible	$325 after deductible	40% after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy $10 group therapy	$30 individual therapy $15 group therapy	40% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	40% 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	40% after deductible
Prescription Drugs (30-day supply)			
Rx–deductible	$300	$300	Medical deductible applies
Rx–generic drugs (Tier 1)	$25	$45	50% after deductible
Rx–preferred brand drugs (Tier 2)	$60 after Rx deductible	$80 after Rx deductible	50% after deductible
Rx–non-preferred brand drugs (Tier 3)	$80 after Rx deductible	$100 after Rx deductible	50% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300 after Rx deductible	50% up to $300 after Rx deductible	50% up to $300 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Gold Flexible Choice[(ie)]** **500 Ded/300 RxDed**		
	Option 1[1]	**Option 2**[1]	**Option 3**[1]
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	$40	$55	40% 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	$40	$60	40% 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)[1]	Not covered	Not covered
Pediatric Vision Services			
Routine eye exam with optometrist	No charge	$30	40% after deductible
Frames	No charge[3]	Not covered	40% after deductible
Lenses	No charge[3]	Not covered	40% after deductible
Contacts	No charge[4]	Not covered	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	$20	$30	40% after deductible
Frames	$125 discount off retail price[5]	Not covered	40% after deductible up to $100
Lenses	$125 discount off retail price[5]	Not covered	40% after deductible up to $150
Contacts	$125 discount off retail price[5]	Not covered	40% after deductible up to $50

For details about (ie) and (iii), see the Definitions section on page 28.

[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. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP **KP VA Gold Flexible Choice[ie] 1,000 Ded/300 RxDed[1]**		
	Option 1[2]	**Option 2[2]**	**Option 3[2]**
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
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	60%/40%
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™, Cigno PPO	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit (copay waived for children under 5 years old)	$30	$40	40% after deductible
Specialty care office visit	$50	$65	40% after deductible
Preventive care/screening/immunization	No charge	No charge	40% after deductible
X-rays and laboratory diagnostic services	X-ray $50/Lab $35	X-ray $70/Lab $55	40% after deductible
MRI/CT/PET	$350 after deductible	$400 after deductible	40% after deductible
Telehealth	No charge	$40 primary care physician/$65 specialist	40% after deductible
Outpatient facility fee	$300 after deductible	$350 after deductible	40% after deductible
Mental health/chemical dependency outpatient services	$30 individual therapy $15 group therapy	$40 individual therapy $20 group therapy	40% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	40% after deductible
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$600 per admission after deductible	$650 per admission after deductible	40% after deductible
Prescription Drugs (30-day supply)			
Rx–deductible	$300	$300	Medical deductible applies
Rx–generic drugs (Tier 1)	$25	$45	50% after deductible
Rx–preferred brand drugs (Tier 2)	$60 after Rx deductible	$80 after Rx deductible	50% after deductible
Rx–non-preferred brand drugs (Tier 3)	$80 after Rx deductible	$100 after Rx deductible	50% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300 after Rx deductible	50% up to $300 after Rx deductible	50% up to $300 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP VA Gold Flexible Choice[ie] 1,000 Ded/300 RxDed[1]		
	Option 1[2]	**Option 2[2]**	**Option 3[2]**
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	$50	$65	40% after deductible
Emergency room	$400 after deductible	Covered in Option 1	Covered in Option 1
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	$50	$70	40% after deductible
Pediatric 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)[2]	Not covered	Not covered
Pediatric Vision Services			
Routine eye exam with optometrist	No charge	$40	40% after deductible
Frames	No charge[4]	Not covered	40% after deductible
Lenses	No charge[4]	Not covered	40% after deductible
Contacts	No charge[5]	Not covered	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	$30	$40	40% after deductible
Frames	$125 discount off retail price[6]	Not covered	40% after deductible up to $100
Lenses	$125 discount off retail price[6]	Not covered	40% after deductible up to $150
Contacts	$125 discount off retail price[6]	Not covered	40% after deductible up to $50

For details about (ie) and (iii), see the Definitions section on page 28.

[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.

[6]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. Please refer to your *EOC* for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Gold Added Choice[id]** **0 Ded/Vision**	
	In-Network	**Out-of-Network**
Individual plan annual deductible (subscriber only)	$0	$3,500
Family plan annual deductible (individual/family)	$0	$3,500/$7,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	$8,600	$10,600
Family plan annual out-of-pocket maximum (individual/family)	$8,600/$17,200	$10,600/$21,200
Network[iii]	KP Signature or Select	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable
BENEFITS		
Outpatient Services		
Primary care office visit (copay waived for children under 5 years old)	$20	$40 after deductible
Specialty care office visit	$50	$60 after deductible
Preventive care/screening/immunization	No charge	20% after deductible
X-rays and laboratory diagnostic services	$50	20% after deductible
MRI/CT/PET	$300	20% after deductible
Telehealth	No charge	Applicable cost shares apply based on type of provider
Outpatient facility fee	$150	20% after deductible
Mental health/chemical dependency outpatient services	$20 individual therapy/$10 group therapy	$40 individual therapy/$20 group therapy (after deductible)
Maternity Services		
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	20% after deductible
Inpatient Services		
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per admission	20% after deductible
Prescription Drugs (30-day supply)		
Rx–deductible	None	Medical deductible applies
Rx–generic drugs (Tier 1)	$20	20% after deductible
Rx–preferred brand drugs (Tier 2)	$70	20% after deductible
Rx–non-preferred brand drugs (Tier 3)	$100	20% after deductible
Rx–specialty drugs (Tier 4)	50% up to $300	50% after deductible up to $300

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP VA Gold Added Choice[(id)] 0 Ded/Vision	
	In-Network	**Out-of-Network**
Urgent Care and Emergency Services		
Urgent care centers (after-hours urgent care)	$50	$60 after deductible
Emergency room	$300 (waived if admitted)	Covered in-plan
Therapy and Rehabilitation Services		
Habilitative and rehabilitative services	$50	$60 after deductible
Pediatric Dental Services		
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	Not covered
Periodic oral evaluation	$0[1]	Not covered
Prophylaxis (cleaning)	$0[1]	Not covered
Topical application of fluoride	$0[1]	Not covered
Pediatric Vision Services		
Routine eye exam with optometrist	No charge	$40 after deductible
Frames	No charge[2]	20% after deductible[2]
Lenses	No charge[2]	20% after deductible[2]
Contacts	No charge[3]	20% after deductible[3]
Adult Vision Services		
Routine eye exam with optometrist	$20	$40 after deductible
Frames	$125 discount off retail price[4]	10% discount off retail price
Lenses	$125 discount off retail price[4]	10% discount off retail price
Contacts	$125 discount off retail price[4]	5% discount off retail price

For details about (ie) and (iii), see the Definitions section on page 28.
[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. Please refer to your *EOC* 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 the Small Business Health Options Program

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Silver[ia]** **1,800 Ded/300 RxDed/Vision**	KP **KP VA Silver Plus[if]** **1,800 Ded/300 RxDed/Vision**		KP S **KP VA Silver[ia]** **2,750 Ded/500 RxDed/Vision**
		Kaiser Permanente Providers	**Out-of-Network Providers**	
Individual plan annual deductible (subscriber only)	$1,800	$1,800	Not applicable	$2,750
Family plan annual deductible (individual/family)	$1,800/$3,600	$1,800/$3,600	Not applicable	$2,750/$5,500
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 S Signature only	KP Signature only	Not applicable	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit (copay waived for children under 5 years old)	$40	$40	$60 (applies to 10-visit limit)	$40
Specialty care office visit	$50 after deductible	$50 after deductible	$80 (applies to 10-visit limit)	$60
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-rays and laboratory diagnostic services	$60 after deductible	$60 after deductible	$80 (applies to 10-visit limit)	$60
MRI/CT/PET	$400 after deductible	$400 after deductible	Not covered	$400 after deductible
Telehealth	No charge	No charge	$60 (applies to 10-visit limit)	No charge
Outpatient facility fee	$350 after deductible	$350 after deductible	Not covered	$350 after deductible
Mental health/chemical dependency outpatient services	$40 individual therapy $20 group therapy	$40 individual therapy $20 group therapy	$60 individual therapy $30 group therapy (applies to 10-visit limit)	$40 individual therapy $20 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	$500 per admission after deductible	$500 per admission after deductible	Not covered	$500 per day up to 3 days per admission after deductible

SILVER PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP VA Silver[ia] 1,800 Ded/300 RxDed/Vision	KP KP VA Silver Plus[if] 1,800 Ded/300 RxDed/Vision		KP S KP VA Silver[ia] 2,750 Ded/500 RxDed/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Prescription Drugs (30-day supply)				
Rx–deductible	$300	$300	Not applicable	$500
Rx–generic drugs (Tier 1)	$20	$20	$40 (each fill/refill applies to the 5-prescription limit)	$25
Rx–preferred brand drugs (Tier 2)	$60 after Rx deductible	$60 after Rx deductible	$80 (each fill/refill applies to the 5-prescription limit)	$60 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 $300 after Rx deductible	50% up to $300 after Rx deductible	60% up to $300 (each fill/refill applies to the 5-prescription limit)	50% up to $300 after Rx deductible
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	$50 after deductible	$50 after deductible	$80	$60
Emergency room	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)	$450 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	$60 after deductible	$60 after deductible	$80 (applies to 10-visit limit)	$60 after deductible
Pediatric Dental Services				
Periodic oral evaluation	$0[1]	$0[1]	Not covered	$0[1]
Prophylaxis (cleaning)	$0[1]	$0[1]	Not covered	$0[1]
Topical application of fluoride	$0[1]	$0[1]	Not covered	$0[1]
Bitewing X-rays	$0 (no additional cost for 1 to 4 films)[1]	$0 (no additional cost for 1 to 4 films)[1]	Not covered	$0 (no additional cost for 1 to 4 films)[1]
Pediatric Vision Services				
Routine eye exam with optometrist	No charge	No charge	Not covered	No charge
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), (if), and (iii), see the Definitions section on page 28.

[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 Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Silver[ic] 2,000 Ded/ HSA/Vision**	KP S **KP VA Silver[ic] 3,000 Ded/ HSA/Vision**	KP S **KP VA Silver[ic] 4,000 Ded/ HSA/Vision**	KP **KP VA Silver Added Choice[id] 2,750 Ded/500 RxDed**		KP **KP VA Silver Virtual Forward 3,000 Ded**
				In-Network	**Out-of-Network**	
Individual plan annual deductible (subscriber only)	$2,000	$3,000	$4,000	$2,750	$5,500	$3,000
Family plan annual deductible (individual/family)	N/A (individual)/ $4,000	N/A (individual)/ $6,000	$4,000/$8,000	$2,750/$5,500	$5,500/$11,000	$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	$15,800	$8,800
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	$15,800/$31,600	$8,800/$17,600
Network[iii]	KP Signature or Select S Signature only	KP Signature or Select S Signature only	KP Signature or Select 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	Not applicable	Not applicable
BENEFITS						
Outpatient Services						
Primary care office visit (copay waived for children under 5 years old)	$30 after deductible	$30 after deductible	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	No charge after deductible	$60	$120	$60 after deductible
Preventive care/screening/immunization	No charge	No charge	No charge	No charge	No charge after deductible	No charge
X-rays and laboratory diagnostic services	$40 after deductible	$50 after deductible	No charge after deductible	$60	30% after deductible	$60 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	No charge after deductible	$350 after deductible	30% after deductible	$250 after deductible
Mental health/chemical dependency outpatient services	$30 individual therapy $15 group therapy (after deductible)	$30 individual therapy $15 group therapy (after deductible)	No charge after deductible	$40 individual therapy $20 group therapy	$70 individual therapy $35 group therapy	No charge for the first visit, then $40 individual therapy after deductible; $20 group therapy after deductible
Maternity Services						
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	No charge	No charge after deductible	No charge

SILVER PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP VA Silver[ic] 2,000 Ded/ HSA/Vision	KP S KP VA Silver[ic] 3,000 Ded/ HSA/Vision	KP S KP VA Silver[ic] 4,000 Ded/ HSA/Vision	KP KP VA Silver Added Choice[id] 2,750 Ded/500 RxDed		KP KP VA Silver Virtual Forward 3,000 Ded
				In-Network	Out-of-Network	
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 5 days per admission after deductible	No charge 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	$500	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	$60 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 $300 after deductible	50% up to $300 after deductible	50% up to $300 after deductible	50% up to $300 after Rx deductible	50% up to $300 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	No charge after deductible	$60	$120	$60 after deductible
Emergency room	$400 after deductible (waived if admitted)	$400 after deductible (waived if admitted)	$450 after deductible	$450 after deductible (waived if admitted)	Covered in-plan	$450 after deductible (waived if admitted)
Therapy and Rehabilitation Services						
Habilitative and rehabilitative services	$40 after deductible	$50 after deductible	No charge after deductible	$60 after deductible	$70 after deductible	$60 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]
Pediatric Vision Services						
Routine eye exam with optometrist	No charge after deductible	No charge after deductible	No charge after deductible	No charge	$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]	30% after deductible[3]	No charge[3]

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Silver[ic] 2,000 Ded/ HSA/Vision**	**KP VA Silver[ic] 3,000 Ded/ HSA/Vision**	**KP VA Silver[ic] 4,000 Ded/ HSA/Vision**	**KP VA Silver Added Choice[id] 2,750 Ded/500 RxDed**		**KP VA Silver Virtual Forward 3,000 Ded**
				In-Network	**Out-of-Network**	
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 28.

[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*.

KP Offered through Kaiser Permanente S Offered through the Small Business Health Options Program

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Bronze[ic]** **6,500 Ded/Vision**	KP S **KP VA Bronze[ic]** **6,000 Ded/HSA/Vision**	KP S **KP VA Bronze[ic]** **7,050 Ded/HSA/Vision**
Individual plan annual deductible (subscriber only)	$6,500	$6,000	$7,050
Family plan annual deductible (individual/family)	$6,500/$13,000	$6,000/$12,000	$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 S Signature only	KP Signature or Select S Signature only	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit (copay waived for children under 5 years old)	$50	$30 after deductible	No charge after deductible
Specialty care office visit	$100	$50 after deductible	No charge after deductible
Preventive care/screening/immunization	No charge	No charge	No charge
X-rays and laboratory diagnostic services	X-ray $100/Lab $50 (after deductible)	X-ray $100/Lab $50 (after deductible)	No charge after deductible
MRI/CT/PET	$500 after deductible	$500 after deductible	No charge after deductible
Telehealth	No charge	No charge after deductible	No charge after deductible
Outpatient facility fee	$300 after deductible	$300 after deductible	No charge after deductible
Mental health/chemical dependency outpatient	$50 individual therapy $25 group therapy	$30 individual therapy $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)	$500 per day up to 5 days per admission after deductible	$500 per admission after deductible	No charge after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S **KP VA Bronze(ic)** **6,500 Ded/Vision**	KP S **KP VA Bronze(ic)** **6,000 Ded/HSA/Vision**	KP S **KP VA Bronze(ic)** **7,050 Ded/HSA/Vision**
Prescription Drugs (30-day supply)			
Rx–deductible	Medical deductible applies	Medical deductible applies	Medical deductible applies
Rx–generic drugs (Tier 1)	$35	$10 after deductible	No charge after deductible
Rx–preferred brand drugs (Tier 2)	$80 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 $300 after deductible	50% up to $300 after deductible	No charge after deductible
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	$100	$50 after deductible	No charge after deductible
Emergency room	$550 after deductible (waived if admitted)	$250 after deductible	No charge after deductible
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	$100 after deductible	$100 after deductible	No charge after deductible
Pediatric and Cosmetic 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	No charge	No charge 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 28.

[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 Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP VA Bronze Plus[if] 6,500 Ded/Vision	
	Kaiser Permanente Providers	**Out-Of-Network Providers**
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 (copay waived for children under 5 years old)	$50	$70 (applies to 10-visit limit)
Specialty care office visit	$100	$120 (applies to 10-visit limit)
Preventive care/screening/immunization	No charge	No charge (applies to 10-visit limit)
X-rays and laboratory diagnostic services	X-ray $100 (after deductible)/Lab $50 (after deductible)	X-ray $120/Lab $70 (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	$300 after deductible	Not covered
Mental health/chemical dependency outpatient services	$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)	$500 per day up to 5 days per admission after deductible	Not covered
Prescription Drugs (30-day supply)		
Rx–deductible	Medical deductible applies	Not applicable
Rx–generic drugs (Tier 1)	$35	$55 (each fill/refill applies to the 5-prescription limit)
Rx–preferred brand drugs (Tier 2)	$80 after deductible	$100 (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 $300 after deductible	60% up to $300 (each fill/refill applies to the 5-prescription limit)
Urgent Care and Emergency Services		
Urgent care centers (after-hours urgent care)	$100	$100
Emergency room	$550 after deductible (waived if admitted)	Covered in-plan

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	**KP VA Bronze Plus(if) 6,500 Ded/Vision**	
	Kaiser Permanente Providers	**Out-Of-Network Providers**
Therapy and Rehabilitation Services		
Habilitative and rehabilitative services	$100 after deductible	$120 (applies to 10-visit limit)
Pediatric and Cosmetic 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	No charge	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 (if) and (iii), see the Definitions section on page 28.

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

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

(iii) PHCS™ and MultiPlan® Provider Networks
Both participating provider networks for KPIC available in Option 2 of the Deductible 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 CA, GA, MD, HI, OR, VA, and DC.

COMMONWEALTH OF VIRGINIA

MEDICAL EXCLUSIONS

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

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

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

The following services are excluded from coverage:

Alternative Medical Services

Acupuncture Services and the Services of an acupuncturist, naturopath or massage therapist.

Certain Exams and Services

Physical examinations and other Services:

1. Required for obtaining or maintaining employment or participation in employee programs; or
2. Required for insurance, or licensing; or
3. On court order or required for parole or probation.

Cosmetic Services

Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include, but are not limited to, cosmetic dermatology, cosmetic surgical services and cosmetic dental services.

Custodial Care

Custodial care means assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dental Care

Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome.

This exclusion does not apply to Medically Necessary dental care covered under **Accidental Dental Injury Services, Cleft-Lip, Cleft-Palate or Ectodermal Dysplasia,** or **Oral Surgery** in **Section 3: Benefits, Exclusions and Limitations** or under Dental Plans.

Disposable Supplies

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, Ace-type bandages, and any other supplies, appliances, or devices, not specifically listed as covered in the **Benefits** section.

Durable Medical Equipment

Except as covered under **Durable Medical Equipment** in Section 3, the following items and Services are excluded:

a. Comfort, convenience, or luxury equipment or features;

b. Exercise or hygiene equipment;

c. Non-medical items such as sauna baths or elevators;

d. Modifications to your home or car; and

e. Electronic monitors of the heart or lungs, except infant apnea monitors.

Employer or Government Responsibility

Financial responsibility for Services that an employer or government agency is required by law to provide.

Experimental or Investigational Services

Except as covered under **Clinical Trials** section of the **Benefits** section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is or will be provided to you:

a. It cannot not be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or

b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or

c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating Facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

d. It is the subject of a written protocol used by the treating Facility for research, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the Facility.

In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

a. your medical records,

b. the written protocols or other documents pursuant to which the Service has been or will be provided,

c. any consent documents you or your representative has executed or will be asked to execute, to receive the Service,

d. the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,

e. the published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and

f. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Family Members

Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse or Domestic Partner, child, brother, sister, parent, in-law, or self.

Health Club Memberships and Fitness Services

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even when ordered by a Plan Provider. This exclusion also applies to health spas.

Orthotic Devices

Services and supplies for orthotic devices, except as specifically covered under the **Benefits** section of this *EOC*.

Other Non-Covered Services

1. Inpatient stays for environmental changes
2. Educational therapy
3. Coma stimulation therapy
4. Services, surgeries and drugs to treat sexual deviation and dysfunction
5. Treatment of social maladjustment without signs of a psychiatric disorder
6. Remedial or special education services

Routine Foot Care Services

Except when Medically Necessary, the following foot care Services (palliative or cosmetic) are excluded:

1. Flat foot conditions;
2. Support devices and arch supports;
3. Foot inserts;
4. Orthopedic and corrective shoes not part of a leg brace and fitting;
5. Castings and other services related to devices of the feet;
6. Foot orthotics;
7. Subluxations of the foot;
8. Corns, calluses and care of toenails;
9. Bunions except for capsular or bone surgery;
10. Fallen arches;
11. Weak feet; and
12. Chronic foot strain or symptomatic complaints of the feet.

Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under **Getting a Referral** in **Section 2: How to Get the Care You Need,** we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines. Travel and Lodging Expenses are allowed for the transportation benefit related to transplant surgery.

Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

Worker's Compensation or Employer's Liability

Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, Services during a jail or prison sentence, Services you get from worker's compensation, and Services from free clinics. If worker's compensation benefits are not available to you, this exclusion does not apply. This exclusion will apply if you get the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

MEDICAL LIMITATIONS

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

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or
7. Complete or partial destruction of facilities.

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

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, 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 LIMITATIONS

Dispensing Limitations

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

1. 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.

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

MAINTENANCE MEDICATION DISPENSING LIMITATIONS

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

1. Prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

CONTRACEPTIVE DRUG DISPENSING LIMITATIONS

Members may obtain up to a twelve (12)-month supply of prescription contraceptives in a single prescription, when authorized by the prescribing Plan Provider or a referral physician, pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies.

Limitations

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

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

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

Pharmacy Exclusions

The following drugs are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in **Section 3: Benefits, Exclusions and Limitations.**

Please refer to the applicable benefit to determine if drugs are covered:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List.
2. Compounded preparations that do not contain at least one (1) ingredient requiring a prescription and are not listed in our Preferred Drug List.
3. Take home drugs received from a Hospital, Skilled Nursing Facility or other similar Facility. Refer to Hospital Inpatient Care and Skilled Nursing Facility Care in **Section 3: Benefits, Exclusions and Limitations.**
4. Drugs that are considered to be experimental or investigational. Refer to Clinical Trials in **Section 3: Benefits, Exclusions and Limitations.**
5. Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug:
    a. That can be obtained without a prescription; or
    b. For which there is a non-prescription drug that is the identical chemical equivalent (i.e., the same active ingredient and dosage) to a prescription drug, unless otherwise prohibited by state or federal laws governing Essential Health Benefits.
6. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
7. Drugs or dermatological preparations, ointments, lotions and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
8. Medical foods. Refer to "Medical Foods" in **Section 3: Benefits, Exclusions and Limitations.**
9. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to Hospice Care in **Section 3: Benefits, Exclusions and Limitations.**
10. Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
11. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
12. Alternative formulations or delivery methods that are different from the Health Plan's standard formulation or delivery method for prescription drugs and deemed not Medically Necessary.
13. Drugs and devices that are provided during a covered stay in a Hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to Drugs, Supplies, and Supplements and Home Health Services in **Section 3: Benefits, Exclusions and Limitations.**
14. Bandages or dressings. Refer to Drugs, Supplies, and Supplements and Home Health Services in **Section 3: Benefits, Exclusions and Limitations.**
15. Diabetic equipment and supplies. Refer to Diabetic Services in **Section 3: Benefits, Exclusions and Limitations.**
16. Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
17. Immunizations and vaccinations solely for the purpose of travel. Refer to Outpatient Care in **Section 3: Benefits, Exclusions and Limitations.**
18. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Health Plan's Pharmacy and Therapeutics Committee. The determination by the Health Plan's Pharmacy and Therapeutics Committee is subject to appeal if the prescribing physician believes the over-the-counter therapeutically equivalent drug is

inappropriate therapy for treatment of the patient's condition.

19. Drugs for weight management.
20. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
21. Drugs that can be obtained without a prescription, except for over-the-counter contraceptive drugs.
22. Drugs 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.

DENTAL 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.

FLEXIBLE CHOICE EXCLUSIONS

EXCLUSIONS

The Services listed below are excluded from coverage, except as covered under Section 3.1 (Option 1-HMO Benefits) and Section 3.2 (Option 2-PPO Benefits and Option 3-Indemnity Benefits) of this *EOC*. These exclusions apply to all Services that would otherwise be covered under this *EOC*. When a Service is not covered, all Services, drugs, or supplies directly related to the non-covered Service are also excluded, even if they would otherwise be covered under this *EOC*. Services that are not Medically Necessary are also excluded.

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

Alternative Medical Services

a. Acupuncture Services and the Services of an Acupuncturist
b. Naturopath or Massage Therapist Services

Ambulance Services

a. Transportation by car, taxi, bus, minivan, and any other type of transportation, even if it is the only way to travel to a Plan Provider.
b. Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider (Excluded for Options 1 and 2 only).

Biofeedback or Hypnotherapy
(Excluded for Options 2 and 3 only)

Biotechnology Drugs and Diagnostic Agents
(Excluded for Options 2 and 3 only)

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.

Clinical Trials

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

Cosmetic Services

a. Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include, but are not limited to, cosmetic dermatology, cosmetic surgical services and cosmetic dental services.

Custodial Care

a. Custodial care means assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dental Care

a. Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome.

This exclusion does not apply to Medically Necessary dental care covered under "Accidental Dental Injury Services," "Cleft-Lip, Cleft-Palate or Ectodermal Dysplasia," or "Oral Surgery" in ***Section 3: Benefits, Exclusions and Limitations*** or under Dental Plans.

Disposable Supplies

a. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, Ace-type bandages, and any other supplies, appliances, or devices, not specifically listed as covered in the "Benefits" section.

Drugs, Supplies and Supplements

a. Drugs for which a prescription is not required by law.
b. Drugs for the treatment of sexual dysfunction disorders.

Durable Medical Equipment

Except as covered under "Durable Medical Equipment" in Section 3, the following items and Services are excluded:

a. Comfort, convenience, or luxury equipment or features;
b. Exercise or hygiene equipment;
c. Non-medical items such as sauna baths or elevators;
d. Modifications to your home or car;
e. Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation;
f. Purchases of Durable Medical Equipment. Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental. (For Options 2 and 3 only).

Emergency Care
(Excluded for Options 2 and 3 only)

a. Charges for non-Emergency services in an Emergency care setting, except for non-Emergency surgical or Ancillary Services provided at a Participating Provider facility by a Non-Participating Provider, to the extent that such charges exceed charges that would have been incurred for the same treatment in a non-Emergency care setting. Final determination as to whether non-Emergency Services were rendered appropriately in an Emergency care setting will rest solely with KPIC. Charges for the screening and treatment necessary for stabilization will be processed at the in-network (Option 1) benefit level.
b. Weekend admission charges for non Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.

Employer or Government Responsibility

a. Financial responsibility for Services that an employer or government agency is required by law to provide.

Experimental or Investigational Services

Except as covered under "Clinical Trials" section of the "Benefits" section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is or will be provided to you:

a. It cannot not be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or

b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or

c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

d. It is the subject of a written protocol used by the treating facility for research, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself.

In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

a. Your medical records,

b. The written protocols or other documents pursuant to which the Service has been or will be provided,

c. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service,

d. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,

e. The published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and

f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

g. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

External Prosthetic and Orthotic Devices

a. Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the "Benefits" section of this *EOC*.

Health Education
(Excluded for Options 2 and 3 only)

a. Health education, including but not limited to: a) stress reduction; b) weight reduction; or d) the services of a dietitian. This exclusion will not apply to treatment of Morbid Obesity.

Hearing Services

a. Batteries, except for those received initially, and cords.

b. This exclusion does not apply to newborn hearing screenings.

Home Health Services

a. Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Coordination of Benefits" section of this *EOC*);

b. Services given by a member of the Member's immediate family;

c. Homemaker Services;

d. Maintenance therapy; or

e. Food and home delivered meals.

Infertility Services

a. Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;

b. Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);

c. Drugs used to treat infertility; or

d. Services to reverse voluntarily induced sterility.

Intermediate Care
(Excluded for Options 2 and 3 only)

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

Morbid Obesity Services
(Excluded for Option 1 only)

a. Services not preauthorized by Health Plan.

Oral Surgery
(Excluded for Options 2 and 3 only)

a. Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures.

b. Orthodontic care, except as required in the treatment of cleft lip, cleft palate, or ectodermal Dysplasia.

Preventive Health Care Services

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

a. Monitoring chronic disease.

b. Follow-up Services after you have been diagnosed with a disease.

c. Services provided when you show signs or symptoms of a specific disease or disease process.

d. Non-routine gynecological Visits.

e. Lab, imaging, and other ancillary Services not included in routine prenatal care.

f. Non-preventive Services performed in conjunction with a sterilization.

g. Lab, imaging, and other ancillary Services associated with sterilizations.

h. Complications that arise after a sterilization procedure.

i. [Over-the-counter contraceptive pills, supplies, and devices.]

j. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

k. Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.

l. [Prescription contraceptives that do not require clinical administration for certain group health coverage that includes FDA-approved contraception

that is separate from Health Plan coverage and furnished through another prescription drug provider.]

Note: Refer to ***Outpatient Care*** for coverage of non-preventive diagnostic tests and other covered Services.

Prosthetic Devices

a. Internally implanted breast prosthetics for cosmetic purposes.

Reconstructive Surgery

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

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

Routine Foot Care Services

Except when Medically Necessary, the following foot care Services (palliative or cosmetic) are excluded:

a. Flat foot conditions;
b. Support devices and arch supports;
c. Foot inserts;
d. Orthopedic and corrective shoes not part of a leg brace and fitting;
e. Castings and other services related to devices of the feet;
f. Foot orthotics;
g. Subluxations of the foot;
h. Corns, calluses and care of toenails;
i. Bunions except for capsular or bone surgery;
j. Fallen arches;
k. Weak feet; and
l. Chronic foot strain or symptomatic complaints of the feet.

Services Outside the United States (Excluded for Options 2 and 3 only)

a. 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.

Sexual Dysfunction Treatment (Excluded for Options 2 and 3 only)

a. Any drug, procedure, or treatment for sexual dysfunction 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.

Skilled Nursing Facility Care

a. Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Coordination of Benefits" section of this *EOC*).
b. Domiciliary care.

See "Therapy; Habilitative and Rehabilitative Services" for coverage of therapy during an inpatient stay.

Surrogacy Arrangements Services (Option 2 and 3)

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

Telemedicine Services

Non-interactive Telemedicine Services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Therapy; Habilitative and Rehabilitative Services

Long-term rehabilitation therapy, except as provided for cardiac rehabilitation Services

Refer to the following benefits in this section for the Habilitative and Rehabilitative devices that are also covered under this Agreement:

a. Diabetic Equipment, Supplies, and Self-Management
b. Durable Medical Equipment
c. Prosthetic Devices, including orthotics
d. Vision Services, including lenses prescribed following surgery or for the treatment of accidental injury

Transplant Services

a. Services related to non-human or artificial organs and their implantation (Excluded for Option 1 only).

Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines. Travel and Lodging Expenses are allowed for the transportation benefit related to transplant surgery.

Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

Vision Services

a. Industrial and athletic safety frames.
b. Eyeglass lenses and contact lenses with no refractive value.
c. Sunglasses without corrective lenses unless Medically Necessary.
d. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), farsightedness (hyperopia), and astigmatism (for example, radial keratotomy, photorefractive keratectomy, and similar procedures).
e. Eye exercises.
f. Non-corrective contact lenses;
g. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
h. Replacement of lost, broken, or damaged lenses frames and contact lenses.
i. Plano lenses.

j. Lens adornment, such as engraving, faceting, or jewelling.
k. Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
l. Orthoptic (eye training) therapy.

Visiting Member Services
(Excluded for Option 1 only)

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in different Kaiser regional health plan or Group Health Cooperative service area.

Worker's Compensation or Employer's Liability

Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, Services during a jail or prison sentence, Services you get from worker's compensation, and Services from free clinics. If worker's compensation benefits are not available to you, this exclusion does not apply. This exclusion will apply if you get the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

Other Non-Covered Services

a. Inpatient stays for environmental changes;
b. Cognitive rehabilitation therapy;
c. Educational therapy;
d. Coma stimulation therapy;
e. Services, surgeries and drugs to treat sexual deviation and dysfunction;
f. Treatment of social maladjustment without signs of a psychiatric disorder; or
g. Remedial or special education services.

Special education and related counseling or therapy; or learning deficiencies. This applies whether or not the services are associated with manifest Mental Illness or other disturbances. (Excluded for Options 2 and 3 only)

Unusual Circumstances

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, terrorist activity, civil insurrection, disability of a large share of personnel of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences.

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. Đá **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, dịịrị 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
2023SG1268 MAS 9/30/23-12/31/24