KAISER PERMANENTE®

Healthy together

Care and coverage that fits your life

Kaiser Permanente for
Individuals and Families

buykp.org

2018 Enrollment | Maryland

Welcome to care that fits your life

Your doctor, your choice

Choose your doctor based on what's important to you. Go to **kp.org/searchdoctors** for details about education, specialties, languages spoken, and more. You can also change doctors at any time.

Convenient cost estimates

Get an idea of what you'll pay before you come in for care. For a personalized estimate based on your plan details, visit **kp.org/costestimates**.

More care options

How you get care is up to you. Choose a phone or video appointment, email your doctor's office with routine questions, or come see us in person.*

Right care, right time

Get the care you need when you need it with routine, specialty, urgent, and emergency care. If you're ever unsure where to go, call us for 24/7 care advice by phone.

Many services under one roof

Do more in less time. In most of our facilities, you can see your doctor, get a lab test, and pick up prescriptions – all in a single trip.

*These features are available when you get care at Kaiser Permanente facilities.

The right choice for your health

Welcome to your Kaiser Permanente for Individuals and Families enrollment guide. This guide will help you select the right health plan for your needs.

Simple steps to apply

Use this guide to help you find a plan that works for you. Then, apply online or fill out a paper application.

Visit **buykp.org/apply** to compare plans, see if you qualify for federal financial assistance, calculate your rate, or apply online.

Important deadline for open enrollment

The open enrollment period for 2018 coverage runs from **November 1, 2017, through December 15, 2017.** You can change or apply for coverage through Kaiser Permanente, or we can help you apply through Maryland Health Connection.

For coverage that starts on January 1, 2018, we must receive your Application for Health Coverage and first month's premium **no later than December 15, 2017.**

Enrolling during a special enrollment period

Are you getting married, having a baby, or losing your health coverage? You may also enroll or change your coverage throughout the year if you have a triggering event (or qualifying life event).

See the Enrolling During a Special Enrollment Period guide for a list of triggering events and instructions. Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) to request a copy.

Your care, your way

Get care where, when, and how you want it. With more options to choose from, it's easier to stay on top of your health.

Choose how you connect to care

Online	Stay on top of your care at **kp.org**. Once you're registered, you can view your medical record, refill most prescriptions, schedule routine appointments, and more. Email your doctor's office anytime with nonurgent questions. You'll usually get a response within 2 business days.
Video	For some conditions, you can meet face-to-face online with your doctor on your computer, smartphone, or tablet*.
Phone	You may be able to save a trip to the doctor's office by having a phone appointment instead. We also offer care guidance and advice by phone 24/7.
In person	Most of our locations have many services under one roof, so you can see your doctor, get lab services or X-rays, and pick up a prescription – all in the same trip.
Online wellness tools	Visit **kp.org/healthyliving** for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs.
Discounts for members	Enjoy discounts on products and services that can help you stay healthy – like gym memberships, massage therapy, and more. Explore your options at **kp.org/choosehealthy**.

Some features are available only when you get care at Kaiser Permanente facilities.

*All video appointments are for certain medical conditions, and for members who are age 18 or older. Routine video visit appointments are with physicians who practice at Kaiser Permanente facilities. During a routine video visit with your doctor, you must be present in Maryland, Virginia, or Washington, DC. For urgent video visits with a doctor, you may also be located in Florida, North Carolina, West Virginia, or Pennsylvania (available weekdays from 10 a.m. to 10 p.m. and weekends from noon to midnight, Eastern time).

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

Choose your health plan

Understanding health plans

We offer a variety of plans to fit your needs and budget. All of them offer the same quality care, but the way they split the costs is different. Learn more below.

Copay plans

Platinum, Gold

Copay plans are the simplest. You know in advance how much you'll pay for care like doctor visits and prescriptions. This amount is called your **copay.** Your monthly rate is higher, but you'll pay much less when you actually get care.

Deductible plans

Gold, Silver, Bronze

With a deductible plan, your monthly rate is lower, but you'll have to reach a deductible. This means you'll pay the full charges for most covered services until you reach a set amount known as your **deductible.** Then you'll start paying less – just a copay or coinsurance. Depending on your plan, some services, like office visits or prescriptions, may be available at a copay or coinsurance before you meet your deductible.

HSA-qualified deductible plans

Silver, Bronze

HSA-qualified deductible plans are deductible plans with a special feature. With this plan, you can set up a health savings account (HSA) to pay for health costs like copays, coinsurance, and deductible payments. And you won't pay federal taxes on the money in this account.

You can use your HSA anytime to pay for care, including some services that may not be covered by your plan, such as eyeglasses, adult dental care, or chiropractic services.* And if you have money left in your HSA at the end of the year, it will roll over for you to use the next year.

*For a complete list of services you can use your HSA to pay for, see Publication 502, *Medical and Dental Expenses,* at irs.gov.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

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Choosing a plan based on your care needs

If you need a lot of care, you may want a plan with a higher monthly rate so that you pay less when you come in for care. If you don't go to the doctor much, you may want a plan with a lower monthly rate, keeping in mind you'll pay more if and when you do get care.

Monthly rate versus out-of-pocket costs

Plan level	What you pay for your monthly rate	What you pay when you get care (Emergency Department visit, lab test, etc.)
Platinum		
Gold		
Silver		
Bronze		

An example of costs when you get care

Let's say you hurt your ankle. You visit your primary care doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication. Here's a sample of what you would pay out of pocket for these services with each type of health plan.

Plan name	Office visit	X-ray	Generic drug
KP MD Gold 0/20/Dental (No deductible)	$20 (waived for children after 5)	$40	$10* (waived for children after 5)
KP MD Silver 2000/30/Dental ($2,000 deductible)	$30 (waived for children after 5)	$50	$15*
KP MD Bronze 6200/20%/HSA/Dental ($6,200 deductible)	20% after deductible	20% after deductible	$20 after deductible

The cost estimates above are from our estimate tools website, **kp.org/treatmentestimates**. Visit this site anytime to get an idea of what the charges for common services might be before you meet your deductible.

***Mail order:** 90-day supply of qualified prescriptions for the cost of a 60-day supply.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan's benefits. Review the diagram below to help you understand how to read those charts.

Here's a quick look at how to use the chart

	KP M KP MD Silver 2000/30/Dental
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	$2,000/$4,000
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$30 (waived for children under 5)
Specialty care office visit	$50
Most X-rays	$50
Most lab tests	$30
MRI, CT, PET	35% after deductible
Outpatient surgery	35% after deductible
Mental health visit	$30 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	35% after deductible
Emergency and urgent care	
Emergency Department visit	35% after deductible
Urgent care visit	$50
Prescription drugs (up to a 30-day supply)	
Generic	$15*
Preferred brand	$55 after $750 brand deductible per member
Non-preferred brand	35% after $750 brand deductible per member
Specialty	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription
Whole health	
Healthy services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

*Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply

KP Offered through Kaiser Permanente

M Offered through the Marketplace, Maryland Health Connection

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $2,000 for yourself or $4,000 for your family. Then you'd start paying copays or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than $7,350 for yourself and no more than $14,700 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they're not subject to the deductible.

Covered before you reach the deductible

With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a $30 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance

After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 35% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd pay a $50 copay for urgent care visits, whether or not you have met your deductible.

KP Offered through Kaiser Permanente

M Offered through the Marketplace, Maryland Health Connection

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on marylandhealthconnection.gov.

	KP M KP MD Bronze 6500/50/Dental	KP M KP MD Bronze 6200/20%/HSA/Dental	KP M KP MD Bronze 5500/50/Dental	KP M KP MD Silver 6000/35/Dental	KP M KP MD Silver 3000/30/Dental	KP M KP MD Silver 2750/20%/HSA/Dental
Plan type	Deductible	HSA-qualified	Deductible	Deductible	Deductible	HSA-qualified
Features						
Annual medical deductible (individual/family)	$6,500/$13,000	$6,200/$12,400	$5,500/$11,000	$6,000/$12,000	$3,000/$6,000	$2,750/$5,500
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700	$6,550/$13,100	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700	$5,000/$10,000
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	First 2 visits $50, then 40% after deductible†† (copay waived for children under 5)	20% after deductible	First 2 visits $50, then $50 after deductible†† (copay waived for children under 5)	$35 (waived for children under 5)	$30 (waived for children under 5)	20% after deductible
Specialty care office visit	40% after deductible	20% after deductible	$70 after deductible	$55	$50	20% after deductible
Most X-rays	40% after deductible	20% after deductible	$110	$50	$50	20% after deductible
Most lab tests	40% after deductible	20% after deductible	$40	$35	$30	20% after deductible
MRI, CT, PET	40% after deductible	20% after deductible	$625 after deductible	35% after deductible	35% after deductible	20% after deductible
Outpatient surgery	40% after deductible	20% after deductible	35% after deductible	35% after deductible	35% after deductible	20% after deductible
Mental health visit	40% after deductible	20% after deductible	$50 (individual therapy)	$35 (individual therapy)	$30 (individual therapy)	20% after deductible
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	20% after deductible	35% after deductible	35% after deductible	35% after deductible	20% after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	20% after deductible	35% after deductible	35% after deductible	35% after deductible	20% after deductible
Emergency and urgent care						
Emergency Department visit	40% after deductible	20% after deductible	35% after deductible	35% after deductible	35% after deductible	20% after deductible
Urgent care visit	40% after deductible	20% after deductible	$70 after deductible	$55	$50	20% after deductible
Prescription drugs (up to a 30-day supply)						
Generic	40% after deductible	$20 after deductible†	$25†	$20†	$15†	$15 after deductible†
Preferred brand	40% after deductible	50% after deductible	$100 after $1,000 brand deductible per member†	$60 after $750 brand deductible per member†	$55 after $750 brand deductible per member†	$55 after deductible†
Non-preferred brand	40% after deductible	50% after deductible	50% after $1,000 brand deductible per member	35% after $750 brand deductible per member	35% after $750 brand deductible per member	20% after deductible
Specialty	40% after deductible up to $150 maximum per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription	50% after $1,000 brand deductible per member up to $150 maximum per 30-day prescription	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription	30% after deductible up to $150 maximum per 30-day prescription
Whole health						
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

This plan summary is intended to highlight only some of the most frequently asked-about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for more details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **1-800-777-7902**, or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 4 days, there is no charge for covered services related to the admission.

†**Mail order:** 90-day supply of qualified prescriptions for the cost of a 60-day supply.

††Includes 2 office visits at $50 before you reach your deductible. Office visits include primary or outpatient mental health care.

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KP Offered through Kaiser Permanente

M Offered through the Marketplace, Maryland Health Connection

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on marylandhealthconnection.gov.

	KP M KP MD Silver 2000/30/Dental	KP M KP MD Gold 1500/20/Dental	KP M KP MD Gold 1000/20/Dental	KP M KP MD Gold 0/20/Dental	KP M KP MD Platinum 0/5/Dental	KP M KP MD Catastrophic‡ 7350/0/Dental
Plan type	**Deductible**	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features						
Annual medical deductible (individual/family)	$2,000/$4,000	$1,500/$3,000	$1,000/$2,000	None/None	None/None	$7,350/$14,700
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$4,000/$8,000	$7,350/$14,700
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	$30 (waived for children under 5)	$20 (waived for children under 5)	$20 (waived for children under 5)	$20 (waived for children under 5)	$5 (waived for children under 5)	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	$50	$40	$40	$40	$15	No charge after deductible
Most X-rays	$50	$40	$40	$40	$5	No charge after deductible
Most lab tests	$30	$20	$20	$20	$5	No charge after deductible
MRI, CT, PET	35% after deductible	30% after deductible	$500	$500	$150	No charge after deductible
Outpatient surgery	35% after deductible	30% after deductible	30% after deductible	30%	$350	No charge after deductible
Mental health visit	$30 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)	$5 (individual therapy)	First 3 office visits no charge.** Additional visits no charge after deductible.
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30% after deductible	30% after deductible	30%	$350 per day up to 4 days*	No charge after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30% after deductible	30% after deductible	30%	$350 per day up to 4 days*	No charge after deductible
Emergency and urgent care						
Emergency Department visit	35% after deductible	30% after deductible	$500 (waived if admitted)	$500 (waived if admitted)	$250 (waived if admitted)	No charge after deductible
Urgent care visit	$50	$40	$40	$40	$15	No charge after deductible
Prescription drugs (up to a 30-day supply)						
Generic	$15†	$10†	$10†	$10†	$5†	No charge after deductible
Preferred brand	$55 after $750 brand deductible per member†	$30 after $200 brand deductible per member†	$30†	$30†	$30†	No charge after deductible
Non-preferred brand	35% after $750 brand deductible per member	30% after $200 brand deductible per member	30%	30%	$50†	No charge after deductible
Specialty	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription	30% after $200 brand deductible per member up to $150 maximum per 30 day prescription	30% up to $150 maximum per 30-day prescription	30% up to $150 maximum per 30-day prescription	$150†	No charge after deductible
Whole health						
Healthy services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee after deductible for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for more details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **1-800-777-7902**, or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 4 days, there is no charge for covered services related to the admission.

†**Mail order:** 90-day supply of qualified prescriptions for the cost of a 60-day supply.

‡Only applicants under age 30, or applicants age 30 and older who provide a certificate from the Health Insurance Marketplace in Maryland demonstrating hardship or lack of affordable coverage, may purchase a KP MD Catastrophic 7350/0/Dental plan.

**The KP MD Catastrophic 7350/0/Dental plan includes 3 office visits at no charge before you reach your deductible. Office visits include primary or outpatient mental health care.

††Includes 2 office visits at $50 before you reach your deductible. Office visits include primary or outpatient mental health care.

M Offered through the Marketplace, Maryland Health Connection

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through marylandhealthconnection.gov.

	M KP MD Silver 3500/30/CSR/ Dental (6000)	M KP MD Silver 0/15/CSR/ Dental (6000)	M KP MD Silver 0/5/CSR/ Dental (6000)	M KP MD Silver 1700/20%/CSR/ HDHP/Dental (2750)	M KP MD Silver 500/10%/CSR/ HDHP/Dental (2750)	M KP MD Silver 100/5%/CSR/ HDHP/Dental (2750)
Plan type	Deductible	Copayment	Copayment	Deductible	Deductible	Deductible
Features						
Annual medical deductible (individual/family)	$3,500/$7,000	None/None	None/None	$1,700/$3,400	$500/$1,000	$100/$200
Annual out-of-pocket maximum (individual/family)	$5,850/$11,700	$2,400/$4,800	$2,000/$4,000	$5,000/$10,000	$2,250/$4,500	$1,800/$3,600
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	$30 (waived for children under 5)	$15 (waived for children under 5)	$5 (waived for children under 5)	20% after deductible	10% after deductible	5% after deductible
Specialty care office visit	$50	$30	$5	20% after deductible	10% after deductible	5% after deductible
Most X-rays	$50	$20	$5	20% after deductible	10% after deductible	5% after deductible
Most lab tests	$30	$15	$5	20% after deductible	10% after deductible	5% after deductible
MRI, CT, PET	35% after deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Outpatient surgery	35% after deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Mental health visit	$30 (individual therapy)	$15 (individual therapy)	$5 (individual therapy)	20% after deductible	10% after deductible	5% after deductible
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Emergency and urgent care						
Emergency Department visit	35% after deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Urgent care visit	$50	$30	$5	20% after deductible	10% after deductible	5% after deductible
Prescription drugs (up to a 30-day supply)						
Generic	$15†	$10†	$5†	$15 after deductible†	$10 after deductible†	$5 after deductible†
Preferred brand	$55†	$50†	$10†	$55 after deductible†	$35 after deductible†	$10 after deductible†
Non-preferred brand	35%	30%	10%	20% after deductible	10% after deductible	5% after deductible
Specialty	35% up to $150 maximum per 30-day prescription	30% up to $150 maximum per 30-day prescription	10% up to $150 maximum per 30-day prescription	30% after deductible up to $150 maximum per 30-day prescription	10% after deductible up to $150 maximum per 30-day prescription	5% after deductible up to $150 maximum per 30-day prescription
Whole health						
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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*After 4 days, there is no charge for covered services related to the admission.

†**Mail order:** 90-day supply of qualified prescriptions for the cost of a 60-day supply.

††Includes 2 office visits at $50 before you reach your deductible. Office visits include primary or outpatient mental health care.

M Offered through the Marketplace, Maryland Health Connection

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through marylandhealthconnection.gov.

	M KP MD Silver 1750/30/CSR/ Dental (2000)	M KP MD Silver 0/10/CSR/Dental (2000)	M KP MD Silver 0/5/CSR/Dental (2000)	M KP MD Silver 1750/30/CSR/ Dental (3000)	M KP MD Silver 0/10/CSR/ Dental (3000)	M KP MD Silver 0/5/CSR/ Dental (3000)
Plan type	Deductible	Copayment	Copayment	Deductible	Copayment	Copayment
Features						
Annual medical deductible (individual/family)	$1,750/$3,500	None/None	None/None	$1,750/$3,500	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$5,850/$11,700	$2,350/$4,700	$1,800/$3,600	$5,850/$11,700	$2,350/$4,700	$1,800/$3,600
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	$30 (waived for children under 5)	$10 (waived for children under 5)	$5 (waived for children under 5)	$30 (waived for children under 5)	$10 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$50	$20	$5	$50	$20	$5
Most X-rays	$50	$30	$5	$50	$30	$5
Most lab tests	$30	$20	$5	$30	$20	$5
MRI, CT, PET	35% after deductible	30%	10%	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%	35% after deductible	30%	10%
Mental health visit	$30 (individual therapy)	$10 (individual therapy)	$5 (individual therapy)	$30 (individual therapy)	$10 (individual therapy)	$5 (individual therapy)
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%	35% after deductible	30%	10%
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%	35% after deductible	30%	10%
Emergency and urgent care						
Emergency Department visit	35% after deductible	30%	10%	35% after deductible	30%	10%
Urgent care visit	$50	$20	$5	$50	$20	$5
Prescription drugs (up to a 30-day supply)						
Generic	$15†	$10†	$5†	$15†	$10†	$5†
Preferred brand	$55 after $750 brand deductible per member†	$45†	$10†	$55 after $750 brand deductible per member†	$45†	$10†
Non-preferred brand	35% after $750 brand deductible per member	30%	10%	35% after $750 brand deductible per member	30%	10%
Specialty	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription	30% up to $150 maximum per 30-day prescription	20% up to $150 maximum per 30-day prescription	35% after $750 brand deductible per member up to $150 maximum per 30-day prescription	30% up to $150 maximum per 30-day prescription	20% up to $150 maximum per 30-day prescription
Whole health						
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for more details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **1-800-777-7902**, or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 4 days, there is no charge for covered services related to the admission.

†**Mail order:** 90-day supply of qualified prescriptions for the cost of a 60-day supply.

††Includes 2 office visits at $50 before you reach your deductible. Office visits include primary or outpatient mental health care.

Find your rate

Use the monthly rates charts on the following pages, or apply on **buykp.org/apply** to have your rate calculated automatically. Along with your monthly rate, consider what you'll need to pay when you get care. See page 4 for more information.

What determines your rate?

Your rate is based on the following:

- The plan you select
- Where you live, based on your county and ZIP code
- Your age on your start date (effective date)
- If you add an optional dental rider for family members 19 and older
- If you qualify for federal financial assistance. Visit **buykp.org/apply** or call us at **1-800-494-5314** to see if you may qualify.

Interested in a family plan?

Find the rate for each family member, based on his or her age on the start date.

- You
- Your spouse/domestic partner
- All adult children 21 through 25
- Your 3 oldest children under 21

If you have more than 3 children under 21, you only have to pay for the 3 oldest. The other children under 21 will be covered at no charge.

The rates in the monthly rates charts apply to the ZIP codes below. Please check that your ZIP code is listed below. If it isn't, call us at **1-800-494-5314** for information on other rate areas.

ZIP codes for Maryland				
20588	20768–79	20901–08	21092–94	21273
20601–04	20781–85	20910–16	21102	21275
20607–08	20787–88	20918	21104–06	21278–82
20610	20790–92	20993	21108	21284–90
20612–13	20794	20997	21111	21297–98
20616–17	20797	21001	21113–14	21401–05
20623	20799	21005	21117	21409
20637	20810–18	21009–10	21120	21411–12
20639–40	20824–25	21012–15	21122–23	21701–05
20643	20827	21017–18	21128	21709–10
20645–46	20830	21020	21130–33	21714
20658	20832–33	21022–23	21136	21716–18
20675	20837–39	21027–32	21139–40	21723
20677–78	20841–42	21034–37	21144	21737–38
20689	20847–55	21040–48	21146	21754–55
20695	20857	21050–54	21150	21757–59
20697	20859–62	21056–57	21152–58	21762
20701	20866	21060–62	21160–63	21765
20703–12	20868	21065	21201–31	21769–71
20714–26	20871–72	21071	21233–37	21774–77
20731–33	20874–80	21074–78	21239–41	21784
20735–38	20882–86	21082	21244	21787
20740–55	20889	21084–85	21250–52	21790–94
20757–59	20891–92	21087–88	21263–64	21797
20762–65	20894–99	21090	21270	

2018 Monthly rates

Please note: These rates do not include the federal financial assistance you may be eligible to receive through marylandhealthconnection.gov.

Age on 2018 effective date	KP MD Bronze 6500/50/Dental	KP MD Bronze 6200/20%/HSA/ Dental	KP MD Bronze 5500/50/Dental	KP MD Silver 6000/35/Dental	KP MD Silver 3000/30/Dental	KP MD Silver 2750/20%/HSA/ Dental	KP MD Silver 2000/30/Dental	KP MD Gold 1500/20/Dental
0–14	$195.02	$188.16	$208.69	$223.56	$239.36	$233.81	$245.10	$269.02
15	212.36	204.88	227.24	243.44	260.64	254.59	266.88	292.93
16	218.98	211.28	234.34	251.03	268.77	262.54	275.22	302.08
17	225.61	217.67	241.43	258.63	276.91	270.48	283.55	311.22
18	232.75	224.56	249.07	266.82	285.67	279.04	292.52	321.07
19	239.89	231.45	256.70	275.00	294.43	287.60	301.49	330.91
20	247.28	238.58	264.62	283.47	303.50	296.46	310.78	341.11
21	254.93	245.96	272.80	292.24	312.89	305.63	320.39	351.66
22	254.93	245.96	272.80	292.24	312.89	305.63	320.39	351.66
23	254.93	245.96	272.80	292.24	312.89	305.63	320.39	351.66
24	254.93	245.96	272.80	292.24	312.89	305.63	320.39	351.66
25	255.95	246.94	273.89	293.41	314.14	306.85	321.67	353.07
26	261.05	251.86	279.35	299.25	320.40	312.97	328.08	360.10
27	267.17	257.77	285.89	306.27	327.91	320.30	335.77	368.54
28	277.11	267.36	296.53	317.66	340.11	332.22	348.26	382.25
29	285.27	275.23	305.26	327.02	350.12	342.00	358.52	393.51
30	289.35	279.16	309.63	331.69	355.13	346.89	363.64	399.13
31	295.46	285.07	316.18	338.71	362.64	354.23	371.33	407.57
32	301.58	290.97	322.72	345.72	370.15	361.56	379.02	416.01
33	305.41	294.66	326.81	350.10	374.84	366.14	383.83	421.29
34	309.49	298.60	331.18	354.78	379.85	371.03	388.95	426.92
35	311.52	300.56	333.36	357.12	382.35	373.48	391.52	429.73
36	313.56	302.53	335.54	359.46	384.85	375.92	394.08	432.54
37	315.60	304.50	337.73	361.79	387.36	378.37	396.64	435.36
38	317.64	306.47	339.91	364.13	389.86	380.81	399.21	438.17
39	321.72	310.40	344.27	368.81	394.87	385.71	404.33	443.79
40	325.80	314.34	348.64	373.48	399.87	390.60	409.46	449.42
41	331.92	320.24	355.19	380.50	407.38	397.93	417.15	457.86
42	337.78	325.90	361.46	387.22	414.58	404.96	424.52	465.95
43	345.94	333.77	370.19	396.57	424.59	414.74	434.77	477.20
44	356.14	343.61	381.10	408.26	437.11	426.97	447.58	491.27
45	368.12	355.17	393.92	421.99	451.81	441.33	462.64	507.80
46	382.40	368.94	409.20	438.36	469.34	458.45	480.59	527.49
47	398.46	384.44	426.39	456.77	489.05	477.70	500.77	549.64
48	416.81	402.14	446.03	477.81	511.58	499.71	523.84	574.96
49	434.91	419.61	465.40	498.56	533.79	521.40	546.59	599.93
50	455.30	439.28	487.22	521.94	558.82	545.86	572.22	628.06
51	475.44	458.72	508.77	545.03	583.54	570.00	597.53	655.85
52	497.62	480.11	532.51	570.45	610.76	596.59	625.40	686.44
53	520.06	501.76	556.51	596.17	638.30	623.49	653.60	717.39
54	544.28	525.12	582.43	623.93	668.02	652.52	684.03	750.79
55	568.49	548.49	608.34	651.70	697.74	681.55	714.47	784.20
56	594.75	573.82	636.44	681.80	729.97	713.03	747.47	820.42
57	621.26	599.40	664.81	712.19	762.51	744.82	780.79	857.00
58	649.56	626.71	695.09	744.63	797.24	778.75	816.35	896.03
59	663.58	640.23	710.10	760.70	814.45	795.55	833.98	915.37
60	691.88	667.54	740.38	793.14	849.18	829.48	869.54	954.41
61	716.35	691.15	766.57	821.19	879.22	858.82	900.30	988.16
62	732.41	706.64	783.75	839.61	898.93	878.07	920.48	1010.32
63	752.55	726.07	805.31	862.69	923.65	902.22	945.79	1038.10
64+	764.79	737.88	818.40	876.72	938.67	916.89	961.17	1054.98

Rates are effective January 1, 2018, through December 31, 2018.

2018 Monthly rates

Please note: These rates do not include the federal financial assistance you may be eligible to receive through marylandhealthconnection.gov.

Age on 2018 effective date	KP MD Gold 1000/20/Dental	KP MD Gold 0/20/ Dental	KP MD Platinum 0/5/Dental	KP MD Catastrophic 7350/0/Dental	KP MD Silver 3500/30/CSR/ Dental (6000) KP MD Silver 0/15/ CSR/Dental (6000) KP MD Silver 0/5/ CSR/Dental (6000)	KP MD Silver 1700/20%/CSR/ HDHP/Dental (2750) KP MD Silver 500/10%/CSR/ HDHP/Dental (2750) KP MD Silver 100/5%/CSR/HDHP/ Dental (2750)	KP MD Silver 1750/30/CSR/ Dental (2000) KP MD Silver 0/10/ CSR/Dental (2000) KP MD Silver 0/5/ CSR/Dental (2000)	KP MD Silver 1750/30/CSR/ Dental (3000) KP MD Silver 0/10/ CSR/Dental (3000) KP MD Silver 0/5/ CSR/Dental (3000)
0–14	$272.49	$281.87	$314.83	$177.24	$223.56	$233.81	$245.10	$239.36
15	296.71	306.93	342.81	193.00	243.44	254.59	266.88	260.64
16	305.97	316.51	353.51	199.02	251.03	262.54	275.22	268.77
17	315.23	326.09	364.21	205.05	258.63	270.48	283.55	276.91
18	325.20	336.40	375.74	211.53	266.82	279.04	292.52	285.67
19	335.17	346.72	387.26	218.02	275.00	287.60	301.49	294.43
20	345.50	357.41	399.19	224.74	283.47	296.46	310.78	303.50
21	356.19	368.46	411.54	231.69	292.24	305.63	320.39	312.89
22	356.19	368.46	411.54	231.69	292.24	305.63	320.39	312.89
23	356.19	368.46	411.54	231.69	292.24	305.63	320.39	312.89
24	356.19	368.46	411.54	231.69	292.24	305.63	320.39	312.89
25	357.61	369.93	413.19	232.62	293.41	306.85	321.67	314.14
26	364.74	377.30	421.42	237.25	299.25	312.97	328.08	320.40
27	373.29	386.15	431.29	242.81	306.27	320.30	335.77	327.91
28	387.18	400.52	447.34	251.85	317.66	332.22	348.26	340.11
29	398.58	412.31	460.51	259.26	327.02	342.00	358.52	350.12
30	404.28	418.20	467.10	262.97	331.69	346.89	363.64	355.13
31	412.82	427.05	476.97	268.53	338.71	354.23	371.33	362.64
32	421.37	435.89	486.85	274.09	345.72	361.56	379.02	370.15
33	426.72	441.42	493.02	277.56	350.10	366.14	383.83	374.84
34	432.41	447.31	499.61	281.27	354.78	371.03	388.95	379.85
35	435.26	450.26	502.90	283.13	357.12	373.48	391.52	382.35
36	438.11	453.21	506.19	284.98	359.46	375.92	394.08	384.85
37	440.96	456.15	509.49	286.83	361.79	378.37	396.64	387.36
38	443.81	459.10	512.78	288.69	364.13	380.81	399.21	389.86
39	449.51	465.00	519.36	292.39	368.81	385.71	404.33	394.87
40	455.21	470.89	525.95	296.10	373.48	390.60	409.46	399.87
41	463.76	479.73	535.83	301.66	380.50	397.93	417.15	407.38
42	471.95	488.21	545.29	306.99	387.22	404.96	424.52	414.58
43	483.35	500.00	558.46	314.40	396.57	414.74	434.77	424.59
44	497.60	514.74	574.92	323.67	408.26	426.97	447.58	437.11
45	514.34	532.06	594.26	334.56	421.99	441.33	462.64	451.81
46	534.29	552.69	617.31	347.54	438.36	458.45	480.59	469.34
47	556.72	575.90	643.24	362.13	456.77	477.70	500.77	489.05
48	582.37	602.43	672.87	378.81	477.81	499.71	523.84	511.58
49	607.66	628.59	702.09	395.26	498.56	521.40	546.59	533.79
50	636.16	658.07	735.01	413.80	521.94	545.86	572.22	558.82
51	664.29	687.18	767.52	432.10	545.03	570.00	597.53	583.54
52	695.28	719.23	803.33	452.26	570.45	596.59	625.40	610.76
53	726.63	751.66	839.54	472.65	596.17	623.49	653.60	638.30
54	760.47	786.66	878.64	494.66	623.93	652.52	684.03	668.02
55	794.30	821.67	917.73	516.67	651.70	681.55	714.47	697.74
56	830.99	859.62	960.12	540.53	681.80	713.03	747.47	729.97
57	868.04	897.94	1002.92	564.63	712.19	744.82	780.79	762.51
58	907.57	938.84	1048.60	590.35	744.63	778.75	816.35	797.24
59	927.16	959.10	1071.24	603.09	760.70	795.55	833.98	814.45
60	966.70	1000.00	1116.92	628.81	793.14	829.48	869.54	849.18
61	1000.89	1035.37	1156.43	651.05	821.19	858.82	900.30	879.22
62	1023.33	1058.59	1182.35	665.65	839.61	878.07	920.48	898.93
63	1051.47	1087.69	1214.87	683.95	862.69	902.22	945.79	923.65
64+	1068.57	1105.38	1234.62	695.07	876.72	916.89	961.17	938.67

Rates are effective January 1, 2018, through December 31, 2018.

Learn about dental and vision coverage

With our Kaiser Permanente Individuals and Families dental plans and vision coverage, you get the benefits you need and the high-quality care you've come to expect. There's no waiting period – you can start receiving covered services the minute your coverage takes effect.

A reason to smile

In the Preventive Dental Plan, adults pay a $30 copay for preventive care procedures such as routine cleanings, oral examinations, and topical fluoride, plus bitewing X-rays.

More extensive care is provided at savings of up to 70% or less compared with the usual and customary charges for these services. You pay only the amount listed on the Dominion fee schedule. The combination of predictable costs, no deductibles, and no annual maximums helps you plan for out-of-pocket fees.

Choosing a dentist

You may choose any general dentist from the list of participating dental providers. Specialty care is also available. To see a participating specialist, you'll need a referral from a participating general dentist. These dentists are conveniently located throughout the community.

To locate a participating provider, please visit **dominiondental.com/kaiserdentists** or call Dominion at **1-888-518-5338.**

Quality dental care

With the Preventive Dental Plan, you can be confident that your dentist was carefully selected. All dentists go through a quality assurance program developed in accordance with the National Committee for Quality Assurance (NCQA). This process confirms that each dentist has the required credentials and has passed a thorough on-site office evaluation.

Enhanced adult dental benefits

For an additional premium of $12.93 per month, adults 19 and older can choose to enroll in an enhanced dental plan that offers orthodontic coverage, a $10 copay for most preventive care procedures, and even lower fees on more extensive care than the Preventive Dental Plan. To enroll, select the option on your application to enhance your dental coverage with the dental HMO rider.

Essential vision care

You can get optometry services like routine eye exams, glaucoma screenings, and cataract screenings without a referral from your personal physician. You'll need a referral to get care from an ophthalmologist. Many Kaiser Permanente medical centers have a vision center where you can have exams and purchase quality eyewear and contact lenses. To locate a medical center with a vision center, visit **kp.org/facilities**.

For information about vision coverage and limitations:

Call Member Services at **1-800-777-7902** (TTY **711**), Monday through Friday, from 7:30 a.m. to 9 p.m. (except holidays).

Refer to your *Membership Agreement and Evidence of Coverage*.

Register at **kp.org** and read a summary of your benefits online through My Health Manager.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

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Find a facility near you

Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or visit **kp.org/facilities** to find the one nearest you.

Maryland

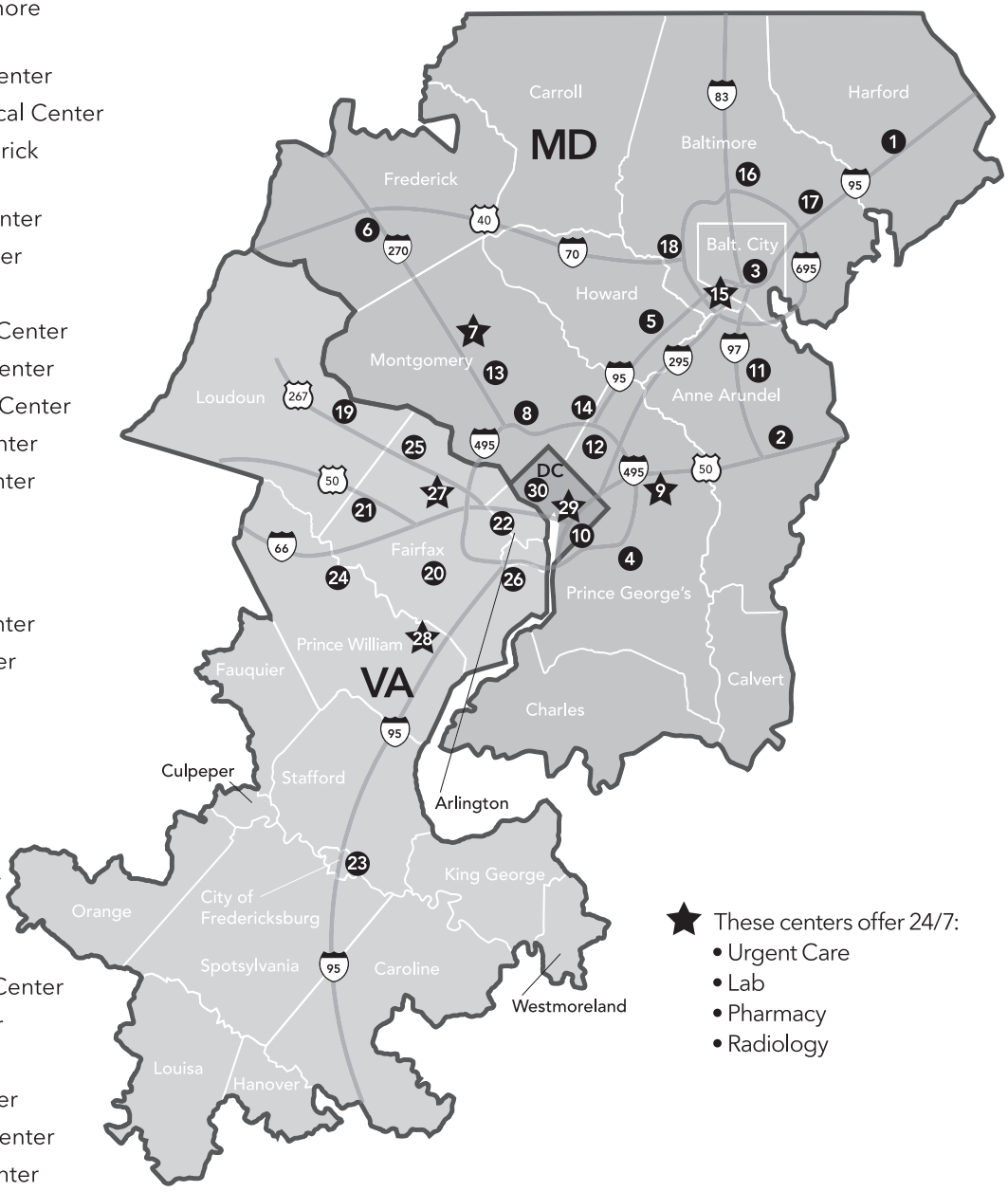
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Camp Springs Medical Center
5 Columbia Gateway Medical Center
6 Kaiser Permanente Frederick Medical Center
7 Gaithersburg Medical Center
8 Kensington Medical Center
9 Largo Medical Center
10 Marlow Heights Medical Center
11 North Arundel Medical Center
12 Prince George's Medical Center
13 Shady Grove Medical Center
14 Silver Spring Medical Center
15 South Baltimore County Medical Center
16 Towson Medical Center
17 White Marsh Medical Center
18 Woodlawn Medical Center

Virginia

19 Ashburn Medical Center
20 Burke Medical Center
21 Fair Oaks Medical Center
22 Falls Church Medical Center
23 Fredericksburg Medical Center
24 Manassas Medical Center
25 Reston Medical Center
26 Springfield Medical Center
27 Tysons Corner Medical Center
28 Woodbridge Medical Center

Washington, D.C.

29 Kaiser Permanente Capitol Hill Medical Center
30 Northwest D.C. Medical Office Building



Please check **kp.org/facilities** for the most up-to-date listing of the services located at Kaiser Permanente medical centers.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

1. A Plan Physician determines that the Services are Medically Necessary;
2. The Services are provided, prescribed, authorized or directed by a Plan Physician; and
   a. You receive the Services at a Plan Facility, Plan Provider or contracted Skilled Nursing Facility inside our Service Area (except when specifically noted otherwise within this Agreement); or
   b. You agree to have Services delivered through a patient centered medical homes program for individuals with chronic conditions, serious illnesses or complex health care needs. This includes associated costs for coordination of care, such as:
      i. Liaison services between the individual and the Health Care Provider, nurse coordinator and the care coordination team;
      ii. Creation and supervision of a care plan;
      iii. Education of the Member and their family regarding the Member's disease, treatment compliance and self-care techniques; and
      iv. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

We will not cover other Services except for:

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in Section 2: How to Get the Care You Need;
4. Approved referrals, as described under Getting a Referral in Section 2: How to Get the Care You Need, including referrals for clinical trials as described in this section.

Note: Some benefits may require payment of a Copayment, Coinsurance or Deductible. Refer to the Summary of Services and Cost Shares Appendix for the Cost Sharing requirements that apply to the covered Services contained within the List of Benefits in this section.

This Agreement does not pay for all health care services, even if they are Medically Necessary. Your right to benefits is limited to the covered Services contained within this contract. To view your benefits, see the List of Benefits in this section.

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under Exclusions in this section.

1. Acupuncture Services

Coverage is provided for Medically Necessary acupuncture Services when provided by a provider licensed to perform such Services.

2. Allergy Services

Coverage is provided for allergy testing and treatment, including the administration of injections and allergy serum.

3. Ambulance Services

Coverage is provided for Ambulance Services when it is Medically Necessary to be transported in an ambulance to or from the nearest Hospital where needed medical Services can be appropriately provided.

4. Anesthesia for Dental Care

We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members who are age:

1. 7 or younger or are developmentally disabled and for whom a:

   a. Superior result can be expected from dental care provided under general anesthesia; and

   b. Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

2. 17 or younger who are extremely uncooperative, fearful or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity and for whom a:

   a. Superior result can be expected from dental care provided under general anesthesia; and

   b. Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

3. 17 and older when the Member's medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by a fully accredited specialist for whom hospital privileges have been granted.

Benefit-Specific Exclusions:

The dentist or specialist's dental care Services; and

Anesthesia and associated facility charges for dental care for temporomandibular joint (TMJ) disorders.

5. Blood

Coverage is provided for all cost recovery expenses for blood, blood products, derivatives, components, biologics and serums, including autologous Services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.

6. Bone Mass Measurement

Coverage is provided for bone mass measurement for the prevention, diagnosis and treatment of osteoporosis when requested by a Health Care Provider for a Qualified Individual. See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

A Qualified Individual means an individual:

1. Who is estrogen deficient and at clinical risk for osteoporosis;
2. With a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
3. Receiving long-term gluco-corticoid (steroid) therapy;
4. With primary hyper-parathyroidism; or
5. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefit-Specific Exclusions:

We do not cover bone mass measurement for Members who do not meet the criteria of a Qualified Individual, as specified under the benefit-specific limitations.

7. Chiropractic Services

Coverage is provided for a limited number of chiropractic visits per condition per Calendar Year. See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

Coverage is limited to up to twenty (20) chiropractic visits per condition per Calendar Year.

8. Clinical Trials

Coverage is provided for Services received in connection with a clinical trial if all of the following conditions are met:

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You provide us with medical and scientific information establishing this determination;
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside of the state in which you live;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application; or
   c. The study or investigation is approved or funded by at least one (1) of the following:
      i. The National Institutes of Health;
      ii. The Centers for Disease Control and Prevention;
      iii. The Agency for Health Care Research and Quality;
      iv. The Centers for Medicare & Medicaid Services;
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
      vii. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:
         a) It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
         b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

Note: For benefits related to a clinical trial, the same Cost Sharing applies that would apply if the Services were not related to a clinical trial.

Coverage will not be restricted solely because the Member received the Service outside of the Service Area or because the Service was provided by a non-Plan Provider.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

We do not cover:

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

9. Durable Medical Equipment

Coverage for Durable Medical Equipment and Prosthetic Devices includes:

1. Durable Medical Equipment such as nebulizers and peak flow meters;
2. International normalized ratio (INR) home testing machines when deemed Medically Necessary by a Plan Physician;
3. Leg, arm, back or neck braces;
4. Internally implanted devices such as monofocal intraocular lens implants;
5. Artificial legs, arms or eyes and the training to use these prosthetics;
6. One (1) hair prosthesis for a Member whose hair loss results from chemotherapy or radiation treatment for cancer; and
7. Ostomy equipment and urological supplies.

10. Emergency Services

Coverage is provided anywhere in the world for reasonable charges for Emergency Services should you experience an Emergency Medical Condition.

If you think you are experiencing an Emergency Medical Condition as defined in the section Important Terms You Should Know, then you should call 911, where available, immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your Kaiser Permanente identification card for immediate medical advice. Any emergency department/room visit that is not attributed to an Emergency Medical Condition, as defined in the section Important Terms You Should Know, will not be authorized by the Health Plan, and you will be responsible for all charges. In situations where the Health Plan authorizes, directs or refers the Member to the emergency room for a condition that is later determined not to meet the definition of an Emergency Medical Condition, the Health Plan would become responsible for charges.

In situations when the Health Plan authorizes, refers or otherwise allows a Member access to a Hospital emergency facility or other Urgent Care facility for a medical condition that requires emergency surgery, the Health Plan will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with the Member's Primary Care Plan Physician.

The Health Plan will not impose any Copayment or other Cost-Sharing requirement for follow-up care that exceeds that which a Member would be required to pay had the follow-up care been rendered in-network, using members of the Health Plan's provider panel.

11. Family Planning Services

Coverage is provided for family planning Services, including:

1. Prescription and over-the-counter contraceptive drugs or devices;
2. Coverage for the insertion or removal of contraceptive devices;
3. Medically Necessary examination associated with the use of contraceptive drugs or devices;
4. Voluntary female and male sterilization; and
5. Voluntary termination of pregnancy.

Note: Family planning Services that are defined as preventive care under the Affordable Care Act are covered at no charge.

Benefit-Specific Exclusions:

Services:

1. To reverse voluntary, surgically induced infertility.
2. To reverse a voluntary sterilization procedure for a Dependent minor.; or
3. For sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.

12. Habilitative Services for Adults

Coverage is provided for Medically Necessary habilitative Services. Habilitative Services means Health Care Services and devices, including Services and devices that help an adult keep, learn or improve skills and functioning for daily living. Habilitative Services for adults includes Medically Necessary therapeutic care.

Therapeutic care means services provided by a speech-language pathologist, occupational therapist or physical therapist.

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

1. Members age 19 or older (beginning on the first day of the month immediately following the month in which the Member reaches age 19):
   a. Physical therapy: Limited to thirty (30) visits per condition, per Calendar Year.
   b. Speech therapy: Limited to thirty (30) visits per condition, per Calendar Year.
   c. Occupational therapy: Limited to thirty (30) visits per condition, per Calendar Year.

13. Habilitative Services for Children

Coverage is provided for Medically Necessary habilitative Services. Habilitative Services means Health Care Services and devices, including Services and devices for the treatment of a child that help the child keep, learn or improve skills and functioning for daily living. Habilitative Services may include Medically Necessary therapeutic care, behavioral health treatment, psychological care, orthodontics, oral surgery, otology, audiological and other Services for people with disabilities in a variety of both inpatient and outpatient settings.

1. Therapeutic care means services provided by a speech-language pathologist, occupational therapist or physical therapist.
2. Behavioral health treatment means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual.
3. Psychological care means direct or consultative services provided by a psychologist or social worker.

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

1. Members from birth to until at least the end of the month the child turns age 19: No visit limits.

The Health Plan will only reimburse for covered habilitative Services provided in the Member's educational setting when the Member's educational setting is identified by the Member's treating provider in a treatment goal as the location of the habilitative Services.

Benefit-Specific Exclusions:

We do not cover habilitative Services delivered through early intervention and school services.

14. Hearing Aids

Coverage is provided for one (1) hearing aid for each hearing-impaired ear every thirty-six (36) months. See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

Replacement batteries to power hearing aids are not covered.

15. Home Health Care Services

Coverage is provided for Home Health Care Services:

1. As an alternative to otherwise covered Services in a Hospital or related institution; and
2. For Members who receive less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle, or who undergo a mastectomy or removal of a testicle on an outpatient basis, including:
   a. One (1) home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and

b. An additional home visit, if prescribed by the Member's attending physician.

For Home Health Care Services related to obstetrical admissions due to childbirth, see the ***Inpatient Hospital Services and Obstetrical Admissions*** *benefit in this* ***List of Benefits****.*

16. Hospice Care Services

Coverage is provided for Hospice Care Services.

17. Infertility Services

Coverage is provided for Medically Necessary infertility Services, including:

1. Services for diagnosis and treatment of involuntary infertility for females and males. Involuntary infertility may be demonstrated by a history of:
   a. Intercourse of at least a two (2) year duration that fails to result in pregnancy, for spouses of the opposite sex only; or
   b. Six (6) attempts of artificial insemination over the course of two (2) years that fails to result in pregnancy, for spouses of the same sex only; or
   c. Infertility that is associated with any of the following medical conditions:
      i. Endometriosis;
      ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
      iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      iv. Abnormal male factors, including oligospermia, contributing to the infertility.
2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider. Refer to the Prescription Drug Appendix, if applicable, for coverage of outpatient infertility drugs;
3. Artificial insemination;
4. In vitro fertilization, including all outpatient expenses arising from in vitro fertilization procedures. We cover in vitro fertilization, if:
   a. The Member's oocytes are fertilized with the Member's spouse's sperm, unless the spouse is unable to produce and deliver functional sperm, provided the inability does not result from a vasectomy or another method of voluntary sterilization; this only applies if the Member and the Member's spouse are a heterosexual couple;
   b. The Member and the Member's spouse have a history of infertility of at least a two (2) years' duration, as described above, or the infertility is associated with any of the medical conditions described above;
   c. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
   d. The in vitro fertilization procedures are performed at medical facilities that conform to the applicable guidelines and standards issued by the American Society for Reproductive Medicine.
5. Coverage for in vitro fertilization embryo transfer cycles, including frozen embryo transfer procedure.
6. Intracytoplasmic sperm injection if the Member meets medical guidelines; and preimplantation genetic diagnosis if the Member meets medical guidelines.

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

Coverage for in vitro fertilization embryo transfer cycles, including frozen embryo transfer procedure, is limited to three (3) in vitro fertilization attempts per live birth.

18. Infusion Services

Coverage is provided for infusion Services, including:

1. Enteral nutrition, which is delivery of nutrients by tube into the gastrointestinal tract; and.

2. All medications administered intravenously and/or parenterally. Infusion Services may be received at multiple sites of service, including facilities, professional provider offices, ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

For additional information on infusion therapy, chemotherapy and radiation, see the ***Infusion Therapy, Chemotherapy and Radiation*** *benefit in this* ***List of Benefits.***

19. Infusion Therapy, Chemotherapy and Radiation

Coverage is provided for chemotherapy, infusion therapy and radiation therapy visits.

Infusion therapy means treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients.

For additional information on Infusion Services, see the ***Infusion Services*** *benefit in this* ***List of Benefits.***

20. Inpatient Hospital Services and Obstetrical Admissions

Coverage is provided for inpatient Hospital Services, including:

1. Room and board, such as:
   a. A ward, semi-private or intensive care accommodations. (A private room is covered only if Medically Necessary);
   b. General nursing care; and
   c. Meals and special diets.

Coverage is also provided for other services and supplies provided by a Hospital.

For obstetrical admissions, inpatient hospitalization coverage is provided, from the time of delivery, for at least forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a normal cesarean section.

For a mother and newborn child who chooses in consultation with her attending provider to remain in the Hospital for less than the minimum period specified above, the Health Plan will provide coverage for and arrange one (1) home health visit to be provided within twenty-four (24) hours after Hospital discharge, and in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child. Additional home health visits may be prescribed by the attending provider.

If the mother is required to remain hospitalized after childbirth for medical reasons, and the mother requests that the baby remain in the Hospital, coverage is provided for the newborn for up to four (4) days.

21. Medical Food

Coverage is provided for medical food for persons with metabolic disorders when ordered by a Health Care Practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

22. Medical Nutrition Therapy and Counseling

Coverage is provided for unlimited Medically Necessary nutritional counseling and medical nutrition therapy provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for an individual at risk due to:

1. Nutritional history;
2. Current dietary intake;
3. Medication use; or
4. Chronic illness or condition.

23. Medical Office Care

Coverage is provided for care in medical offices for treatment of illness or injury.

24. Mental Health and Substance Abuse Services

Coverage is provided for Medically Necessary Services for mental disorders, mental illness, psychiatric conditions and substance abuse for Members includes:

1. Professional Services by providers who are licensed, certified or otherwise authorized professional mental health and substance use practitioners when acting within the scope of their license or certification, such as psychiatrists, psychologists, clinical social workers, licensed

professional counselors or marriage and family therapists.

a. Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include:
   i. Diagnostic evaluation;
   ii. Crisis intervention and stabilization for acute episodes;
   iii. Medication evaluation and management (pharmacotherapy);
   iv. Treatment and counseling, including individual and group therapy;
   v. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
   vi. Opioid treatment Services; and
   vii. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.
b. Electroconvulsive therapy;
c. Inpatient professional fees;
d. Outpatient diagnostic tests provided and billed by a licensed, certified, or otherwise authorized mental health and substance abuse practitioner;
e. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; and
f. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

2. Inpatient hospital and inpatient residential treatment centers Services, which includes room and board, such as:
   a. Ward, semi-private or intensive care accommodations. (A private room is covered only if Medically Necessary);
   b. General nursing care;
   c. Meals and special diets; and
   d. Other services and supplies provided by a hospital or residential treatment center.
3. Services such as partial hospitalization or intensive day treatment programs provided at a facility approved by the Health Plan, which is equipped to provide mental health and substance abuse Services; and
4. Emergency room Services.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

We do not cover:

1. Services by pastoral or marital counselors;
2. Therapy for the improvement of sexual functioning and pleasure;
3. Treatment for learning disabilities and intellectual disabilities;
4. Telephone therapy;
5. Travel time to the Member's home to conduct therapy;
6. Services rendered or billed by schools or halfway houses or members of their staffs;
7. Marriage counseling; and
8. Services that are not Medically Necessary.

25. Morbid Obesity Treatment

Morbid obesity means a body mass index that is:

1. Greater than forty (40) kilograms per meter squared; or
2. Equal to or greater than thirty-five (35) kilograms per meter squared with a comorbid condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Body mass index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Coverage is provided for diagnostic and surgical treatment of morbid obesity that is:

1. Recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and
2. Consistent with guidelines approved by the National Institutes of Health.

Such treatment is covered to the same extent as for other Medically Necessary surgical procedures under this Agreement.

Surgical treatment of morbid obesity shall occur in a facility that is:

1. Designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence; and
2. Designated by the Health Plan.

If the Health Plan does not designate a facility for the surgical treatment of morbid obesity, then the Health Plan shall cover the surgical treatment of morbid obesity at any facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence with an approved referral.

26. Obstetric/Gynecological Care

Coverage is provided for obstetric/gynecological care from an obstetrician/gynecologist or other Plan Provider authorized to perform obstetric and/or gynecological Services, without requiring the woman to visit the Primary Care Plan Physician first, if:

1. The care is Medically Necessary, including the ordering of related obstetrical and gynecological Services;
2. After each visit for gynecological care, the obstetrician/gynecologist communicates with the woman's Primary Care Plan Physician about any diagnosis or treatment rendered; and
3. The obstetrician/gynecologist communicates with the Primary Care Plan Physician before performing any services that are completely unrelated to obstetrical or gynecological care.

27. Outpatient Hospital Services

Coverage is provided for outpatient Hospital Services.

28. Outpatient Laboratory and Diagnostic Services

Coverage is provided for outpatient laboratory and diagnostic Services.

29. Pregnancy and Maternity Services

The Health Plan considers all maternity as routine. All pre-and post-natal Services will be considered preventive care, including all high-risk pregnancy. Coverage is provided for pre-and post-natal services, which includes routine and non-routine office visits, x-ray, lab and specialty tests. Coverage is also provided for:

1. Birthing classes;
2. Breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period; and
3. Inpatient delivery and hospitalization.

30. Prescription Drugs and Devices

Coverage is provided for prescription drugs and devices as described in the Outpatient Prescription Drug Benefit Appendix.

31. Preventive Care Services

Coverage is provided for preventive care Services, including:

1. Evidence-based items or Services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued during or around November 2009 are not considered to be current. Visit: [www.uspreventiveservicestaskforce.org];
2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation from the Advisory Committee on Immunization Practices of the CDC is

considered to be: in effect after it has been adopted by the director of the CDC and for routine use if it is listed on the immunization schedules of the CDC. Visit: [www.cdc.gov/vaccines/recs/ACIP];

3. With respect to infants, children and adolescents: Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. To see the current guidelines, visit: [http://mchb.hrsa.gov];
4. With respect to women (to the extent not described in paragraph "a" above), evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. To see the current guidelines, visit: [http://mchb.hrsa.gov];
5. A voluntary Health Risk Assessment that can be completed by Members annually. Written feedback provided to Members will include recommendations for addressing identified risks;
6. All United States Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity;
7. Routine prenatal care;
8. BRCA counseling and genetic testing. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of service; and
9. Medically Necessary digital tomosynthesis, commonly referred to as three-dimensional "3_D" mammography.

Note: If a new recommendation or guideline described in paragraphs "1" through "4" is issued after the effective date of the Plan, the new recommendation or guideline shall apply the first Calendar Year that begins on the date that is one (1) year after the date of the recommendation or guideline is issued.

The Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

32. Reconstructive Breast Surgery and Breast Prosthesis

Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Mastectomy means the surgical removal of all or part of a breast.

Coverage is provided for:

1. Breast prosthesis;
2. All stages of reconstructive breast surgery performed on the non-diseased breast to achieve symmetry with the diseased breast when reconstructive surgery is performed on the diseased breast; regardless of the patient's insurance status at the time the mastectomy or the time lag between the mastectomy and reconstruction; and
3. Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

32. Routine Foot Care

Coverage is provided for Medically Necessary routine foot care for patients with diabetes or other vascular disease. See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

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

Benefit-Specific Exclusions:

Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

33. Services Approved by the Health Plan

Coverage is provided for any other Service approved by the Health Plan's utilization management program.

34. Skilled Nursing Facility Services

Coverage is provided for Skilled Nursing Facility Services when deemed Medically Necessary. See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

Coverage is limited to a maximum of one-hundred (100) days per Calendar Year.

35. Temporomandibular Joint Services

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
2. Removable appliances for TMJ repositioning; and
3. Therapeutic injections for TMJ.

Benefit-Specific Exclusions:

Fixed or removable appliances that involve movement or repositioning of the teeth.

36. Telemedicine Services

Telemedicine Services. We cover interactive telemedicine services. Telemedicine is the real-time two-way transfer of medical data and information, and such services include the use of interactive audio, video or other electronic media used for the purpose of diagnosis, consultation or treatment as it pertains to the delivery of covered Health Care Services. Equipment utilized for interactive telemedicine should be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.

Benefit-Specific Exclusions:

We do not cover non-interactive telemedicine services consisting of an audio-only telephone conversation, electronic mail message and/or facsimile transmission.

37. Therapy and Rehabilitation Services

Coverage is provided for therapy and rehabilitation Services, including:

1. Unlimited Medically Necessary Hospital inpatient rehabilitative Services;
2. Outpatient rehabilitative Services. Members receive up to thirty (30) visits of:
   a. Physical therapy per condition, per year;
   b. Speech therapy per condition, per year; and
   c. Occupational therapy per condition per year.
3. Cardiac Rehabilitation for Members who have been diagnosed with significant cardiac disease, have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Services include:
   a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription and follow-up examination for physician to adjust medication or change regimen; and
   b. Up to ninety (90) visits per therapy type, per Calendar Year of physical therapy, speech therapy and occupational therapy for Cardiac Rehabilitation.
4. Pulmonary rehabilitation for Members diagnosed with significant pulmonary disease.

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

Cardiac Rehabilitation limitations:

1. Services must be provided at a facility approved

by the Health Plan that is equipped to provide cardiac rehabilitation.

Pulmonary rehabilitation limitations:

1. Services must be provided at a facility approved by the Health Plan that is equipped to provide pulmonary rehabilitation.
2. Coverage is limited to one (1) pulmonary rehabilitation program per lifetime.

Benefit-Specific Exclusions:

We do not cover maintenance programs. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

38. Transplant Services

Coverage is provided for transplant Services for all non-experimental and non-investigational solid organ transplants and other non-solid organ transplant procedures. This includes, but is not limited to, autologous and non-autologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas and pancreas/kidney transplants.

Benefits include the cost of hotel lodging and air transportation for the covered recipient and a companion to and from the authorized site of the transplant. If the covered recipient is under age 18, hotel lodging and air transportation is provided for two (2) companions to and from the authorized site of the transplant.

39. Vision Services

Coverage is provided for Vision Services for:

1. Pediatric Members, up until the end of the month they turn age 19, who may receive:
   a. One (1) routine eye examination each Calendar Year, including dilation if professionally indicated; and
   b. One (1) pair of prescription eyeglass lenses and one (1) frame each Calendar Year from an available selection of frames; or
   c. Contact lenses in lieu of lenses and frames limited to:
      i. Either one (1) pair elective prescription contact lenses from a select group per Calendar Year or multiple pairs of disposable prescription contact lenses from a select group per Calendar Year; or
      ii. Two (2) pair per eye for Medically Necessary contact lenses per Calendar Year;
   a. Low vision services, including: one (1) comprehensive low vision evaluation every five (5) years, four (4) follow-up visits within any five (5) year period and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.
   b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.
2. Adult Members age 19 or older, who may receive:
   a. Routine and necessary eye exams including:
   b. Routine tests such as eye health and glaucoma tests; and
   c. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Note: Discounts are available for certain lenses and frames.

Benefit-Specific Exclusions:

1. Eye exercises.
2. Orthoptic (eye training) therapy.

40. Wellness Benefits

Coverage is provided for wellness benefits, including:

1. A health risk assessment that is completed by each individual on a voluntary basis; and
2. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

Exclusions

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

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this Agreement. The following services are excluded from coverage:

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Other services to the extent they are covered by any government unit, except for veterans in Veterans Administration or armed forces facilities for services received for which the recipient is liable.
5. Services for which a Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. Except for the pediatric vision benefit in the List of Benefits in this section – the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal care services and domiciliary care services.
8. Services rendered by a Health Care Practitioner who is a Member's spouse, mother, father, daughter, son, brother or sister.
9. Experimental services. This exclusion does not apply to Services covered under the clinical trials benefit in the List of Benefits in this section.
10. Practitioner, Hospital or clinical services related to radial keratotomy, myopic keratomileusis and surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
11. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the List of Benefits in this section.
12. Services incurred before the effective date of coverage for a Member.
13. Services incurred after a Member's termination of coverage, except as provided under Extension of Benefits in Section 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership.
14. Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.
15. Services for injuries or diseases related to a Member's job to the extent the Member is required to be covered by a workers' compensation law.
16. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment.
18. Charges for telephone consultations, failure to keep a scheduled visit or completion of any form.
19. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.

20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in the List of Benefits in this section.
21. Travel, whether or not it is recommended by a Health Care Practitioner, except for:
    a. Covered ambulance Services; and
    b. Travel in connection with a covered transplant.
22. Except for Emergency Services and Urgent Care Services, services received while the Member is outside of the United States.
23. Unless otherwise specified in the List of Benefits in this section, or the Adult Dental Plan or Pediatric Dental Plan (whichever applies): Dental work or treatment that includes Hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures;
    b. Orthodontic care or malocclusion;
    c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident; and
    d. Dental implants.
24. Except as provided under the Adult Dental Plan or Pediatric Dental Plan (whichever applies): Accidents occurring while and as a result of chewing.
25. Routine foot care, except for Medically Necessary treatment for patients with diabetes or other vascular disease, as described in the List of Benefits in this section.
26. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting, unless these services are deemed to be Medically Necessary.
27. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
28. Gamete intrafallopian transfers (GIFT) and zygote intrafallopian transfers (ZIFT)
29. Treatment of sexual dysfunction not related to organic disease.
30. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
31. Non-human organs and their implantation.
32. Non-replacement fees for blood and blood products.
33. Lifestyle improvements or physical fitness programs, unless included in List of Benefits in this section.
34. Wigs or cranial prosthesis, except for one (1) hair prosthesis for a Member whose hair loss was the result of chemotherapy or radiation treatment for cancer as noted above in the List of Benefits in this section.
35. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
36. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
37. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
38. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
39. Services for, or related to, the removal of an organ from a Member for the purposes of transplantation into another person unless the:
    a. Transplant recipient is covered under the Health Plan and is undergoing a covered transplant; and
    b. Services are not payable by another carrier.

40. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
41. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
42. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
43. Private duty nursing, unless authorized by the Health Plan.
44. Any claim, bill or other demand or request for payment for Health Care Services determined to be furnished as a result of a referral prohibited by §1-302 of the Health Occupations Article.

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 Office; 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.

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.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **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) સુચના: 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**).

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