KAISER PERMANENTE®

Healthy together

Care and coverage that fits your life

Kaiser Permanente for
Individuals and Families

buykp.org

2018 Enrollment | Virginia

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 the Health Insurance Marketplace.

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. Learn more at **kp.org**.*
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, D.C. 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.

60631708 VA 2018

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

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.

60631708 VA 2018

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 VA Gold 0/20/Dental (No deductible)	$20 (waived for children under 5)	$40	$10*
KP VA Silver 2000/30/Dental ($2,000 deductible)	$30 (waived for children under 5)	$50	$15*
KP VA Bronze 5500/50 Dental ($5,500 deductible)	2 visits $50, then $50 after deductible* (copay waived for children under 5)	$110	$25*

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.

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

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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 VA 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 $250 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 Health Insurance Marketplace

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 Health Insurance Marketplace

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

	KP M KP VA Bronze 5500/50/Dental	KP M KP VA Silver 6000/35/Dental	KP M KP VA Standard Silver 3500/30/Dental	KP M KP VA Silver 3000/30/Dental	KP M KP VA Silver 2750/20%/HSA/Dental	KP M KP VA Silver 2000/30/Dental
Plan type	Deductible	Deductible	Deductible	Deductible	HSA-qualified	Deductible
Features						
Annual medical deductible (individual/family)	$5,500/$11,000	$6,000/$12,000	$3,500/$7,000	$3,000/$6,000	$2,750/$5,500	$2,000/$4,000
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700	$5,000/$10,000	$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	First 2 visits, $50 then $50 after deductible†† (waived for children under 5)	$35 (waived for children under 5)	$30	$30 (waived for children under 5)	20% after deductible	$30 (waived for children under 5)
Specialty care office visit	$70 after deductible	$55	$65	$50	20% after deductible	$50
Most X-rays	$110	$50	20% after deductible	$50	20% after deductible	$50
Most lab tests	$40	$35	20% after deductible	$30	20% after deductible	$30
MRI, CT, PET	$625 after deductible	35% after deductible	20% after deductible	35% after deductible	20% after deductible	35% after deductible
Outpatient surgery	35% after deductible	35% after deductible	20% after deductible	35% after deductible	20% after deductible	35% after deductible
Mental health visit	$50 (individual therapy)	$35 (individual therapy)	$30 (individual therapy)	$30 (individual therapy)	20% after deductible	$30 (individual therapy)
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	35% after deductible	20% after deductible	35% after deductible	20% after deductible	35% 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	35% after deductible	20% after deductible	35% after deductible	20% after deductible	35% after deductible
Emergency and urgent care						
Emergency Department visit	35% after deductible	35% after deductible	20% after deductible	35% after deductible	20% after deductible	35% after deductible
Urgent care visit	$70 after deductible	$55	$75	$50	20% after deductible	$50
Prescription drugs (up to a 30-day supply)						
Generic	$25†	$20†	$15†	$15†	$15 after deductible†	$15†
Preferred brand	$100 after $1,000 brand deductible per member†	$60 after $750 brand deductible per member†	$50†	$55 after $750 brand deductible per member†	$55 after deductible†	$55 after $750 brand deductible per member†
Non-preferred brand	50% after $1,000 brand deductible per member	35% after $750 brand deductible per member	$100†	35% after $750 brand deductible per member	20% after deductible	35% after $750 brand deductible per member
Specialty	50% after $1,000 brand deductible per member up to $250 maximum per 30-day prescription	35% after $750 brand deductible per member up to $250 maximum per 30-day prescription	40% after $500 individual/$1,000 family brand deductible	35% after $750 brand deductible per member up to $250 maximum per 30-day prescription	30% after deductible up to $250 maximum per 30-day prescription	35% after $750 brand deductible per member up to $250 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 Health Insurance Marketplace

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

	KP M KP VA Gold 1500/20/Dental	KP M KP VA Gold 1000/20/Dental	KP M KP VA Gold 0/20/Dental	KP M KP VA Platinum 0/5/Dental	KP M KP VA Catastrophic‡ 7350/0/Dental
Plan type	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features					
Annual medical deductible (individual/family)	$1,500/$3,000	$1,000/$2,000	None/None	None/None	$7,350/$14,700
Annual out-of-pocket maximum (individual/family)	$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
Outpatient services (per visit or procedure)					
Primary care office visit	$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	$40	$40	$40	$15	No charge after deductible
Most X-rays	$40	$40	$40	$5	No charge after deductible
Most lab tests	$20	$20	$20	$5	No charge after deductible
MRI, CT, PET	30% after deductible	$500	$500	$150	No charge after deductible
Outpatient surgery	30% after deductible	30% after deductible	30%	$350	No charge after deductible
Mental health visit	$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	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
Delivery and inpatient well-baby care	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	30% after deductible	$500 (waived if admitted)	$500 (waived if admitted)	$250 (waived if admitted)	No charge after deductible
Urgent care visit	$40	$40	$40	$15	No charge after deductible
Prescription drugs (up to a 30-day supply)					
Generic	$10†	$10†	$10†	$5†	No charge after deductible
Preferred brand	$30 after $200 brand deductible per member†	$30†	$30†	$30†	No charge after deductible
Non-preferred brand	30% after $200 brand deductible per member	30%	30%	$50†	No charge after deductible
Specialty	30% after $200 brand deductible per member up to $250 maximum per 30-day prescription	30% up to $250 maximum per 30-day prescription	30% up to $250 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 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 Virginia demonstrating hardship or lack of affordable coverage, may purchase a KP VA Catastrophic 7350/0/Dental plan.

**The KP VA 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.

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M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Silver 3500/30/ CSR/Dental (6000)	M KP VA Silver 0/15/CSR/ Dental (6000)	M KP VA Silver 0/5/CSR/ Dental (6000)	M KP VA Standard Silver 3000/30/CSR/Dental (3500)	M KP VA Standard Silver 700/10/CSR/Dental (3500)
Plan type	**Deductible**	**Copayment**	**Copayment**	**Deductible**	**Deductible**
Features					
Annual medical deductible (individual/family)	$3,500/$7,000	None/None	None/None	$3,000/$6,000	$700/$1,400
Annual out-of-pocket maximum (individual/family)	$5,850/$11,700	$2,400/$4,800	$2,000/$4,000	$5,850/$11,700	$2,450/$4,900
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	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)	$30	$10
Specialty care office visit	$50	$30	$5	$65	$25
Most X-rays	$50	$20	$5	20% after deductible	20% after deductible
Most lab tests	$30	$15	$5	20% after deductible	20% after deductible
MRI, CT, PET	35% after deductible	30%	10%	20% after deductible	20% after deductible
Outpatient surgery	35% after deductible	30%	10%	20% after deductible	20% after deductible
Mental health visit	$30 (individual therapy)	$15 (individual therapy)	$5 (individual therapy)	$30 (individual therapy)	$10 (individual therapy)
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%	20% after deductible	20% after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%	20% after deductible	20% after deductible
Emergency and urgent care					
Emergency Department visit	35% after deductible	30%	10%	20% after deductible	20% after deductible
Urgent care visit	$50	$30	$5	$75	$40
Prescription drugs (up to a 30-day supply)					
Generic	$15†	$10†	$5†	$15†	$5†
Preferred brand	$55†	$50†	$10†	$50†	$25†
Non-preferred brand	35%	30%	10%	$100†	$50†
Specialty	35% up to $250 maximum per 30-day prescription	30% up to $250 maximum per 30-day prescription	10% up to $250 maximum per 30-day prescription	40% after $200 individual/$400 family brand deductible	30%
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)

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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.

KAISER PERMANENTE®

M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Standard Silver 250/5/CSR/ Dental (3500)	M KP VA Silver 1700/20%/CSR/HDHP/ Dental (2750)	M KP VA Silver 500/10%/CSR/HDHP/ Dental (2750)	M KP VA Silver 100/5%/CSR/HDHP/ Dental (2750)	M KP VA Silver 1750/30/CSR/ Dental (2000)
Plan type	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Features					
Annual medical deductible (individual/family)	$250/$500	$1,700/$3,400	$500/$1,000	$100/$200	$1,750/$3,500
Annual out-of-pocket maximum (individual/family)	$1,250/$2,500	$5,000/$10,000	$2,250/$4,500	$1,800/$3,600	$5,850/$11,700
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	$5	20% after deductible	10% after deductible	5% after deductible	$30 (waived for children under 5)
Specialty care office visit	$10	20% after deductible	10% after deductible	5% after deductible	$50
Most X-rays	5% after deductible	20% after deductible	10% after deductible	5% after deductible	$50
Most lab tests	5% after deductible	20% after deductible	10% after deductible	5% after deductible	$30
MRI, CT, PET	5% after deductible	20% after deductible	10% after deductible	5% after deductible	35% after deductible
Outpatient surgery	5% after deductible	20% after deductible	10% after deductible	5% after deductible	35% after deductible
Mental health visit	$5 (individual therapy)	20% after deductible	10% after deductible	5% after deductible	$30 (individual therapy)
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	5% after deductible	20% after deductible	10% after deductible	5% after deductible	35% after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	5% after deductible	20% after deductible	10% after deductible	5% after deductible	35% after deductible
Emergency and urgent care					
Emergency Department visit	5% after deductible	20% after deductible	10% after deductible	5% after deductible	35% after deductible
Urgent care visit	$25	20% after deductible	10% after deductible	5% after deductible	$50
Prescription drugs (up to a 30-day supply)					
Generic	$3†	$15 after deductible†	$10 after deductible†	$5 after deductible†	$15†
Preferred brand	$5†	$55 after deductible†	$35 after deductible†	$10 after deductible†	$55 after $750 brand deductible per member†
Non-preferred brand	$10†	20% after deductible	10% after deductible	5% after deductible	35% after $750 brand deductible per member
Specialty	25%	20% after deductible up to $250 maximum per 30-day prescription	10% after deductible up to $250 maximum per 30-day prescription	5% after deductible up to $250 maximum per 30-day prescription	35% after $750 brand deductible per member up to $250 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)

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.

KAISER PERMANENTE®

M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Silver 0/10/CSR/ Dental (2000)	M KP VA Silver 0/5/CSR/ Dental (2000)	M KP VA Silver 1750/30/CSR/ Dental (3000)	M KP VA Silver 0/10/CSR/ Dental (3000)	M KP VA Silver 0/5/CSR/ Dental (3000)
Plan type	**Copayment**	**Copayment**	**Deductible**	**Copayment**	**Copayment**
Features					
Annual medical deductible (individual/family)	None/None	None/None	$1,750/$3,500	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$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
Outpatient services (per visit or procedure)					
Primary care office visit	$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	$20	$5	$50	$20	$5
Most X-rays	$30	$5	$50	$30	$5
Most lab tests	$20	$5	$30	$20	$5
MRI, CT, PET	30%	10%	35% after deductible	30%	10%
Outpatient surgery	30%	10%	35% after deductible	30%	10%
Mental health visit	$10 (individual therapy)	$5	$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	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
Delivery and inpatient well-baby care	30%	10%	35% after deductible	30%	10%
Emergency and urgent care					
Emergency Department visit	30%	10%	35% after deductible	30%	10%
Urgent care visit	$20	$5	$50	$20	$5
Prescription drugs (up to a 30-day supply)					
Generic	$10†	$5†	$15†	$10†	$5†
Preferred brand	$45†	$10†	$55 after $750 brand deductible per member†	$45†	$10†
Non-preferred brand	30%	10%	35% after $750 brand deductible per member	30%	10%
Specialty	30% up to $250 maximum per 30-day prescription	20% up to $250 maximum per 30-day prescription	35% after $750 brand deductible per member up to $250 maximum per 30-day prescription	30% up to $250 maximum per 30-day prescription	20% up to $250 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)

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 use tobacco
- 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
- 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 Virginia				
20101–05	20194–97	22121–22	22301–15	22534–35
20108–13	20598	22124–25	22320	22538
20117–22	22003	22134–35	22331–34	22544–47
20124	22009	22150–53	22350	22551
20129	22015	22156	22401–08	22553–56
20131–32	22025–27	22158–61	22412	22565
20134–37	22030–44	22172	22430	22567
20141–43	22046	22180–83	22443	22580
20146–49	22060	22185	22446	22720
20151–53	22066–67	22191–95	22448	22728
20155–56	22079	22199	22451	22736
20158–60	22081–82	22201–07	22463	22960
20163–72	22095–96	22209–17	22471	23015
20175–78	22101–03	22219	22481	23024
20180–82	22106–09	22225–27	22485	23117
20184	22116	22230	22508	23170
20189–92	22118–19	22240–46	22526	

2018 Non-tobacco monthly rates

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

Age on 2018 effective date	KP VA Bronze 5500/50/Dental	KP VA Silver 6000/35/Dental	KP VA Standard Silver 3500/30/ Dental	KP VA Silver 3000/30/Dental	KP VA Silver 2750/20%/HSA/ Dental	KP VA Silver 2000/30/Dental	KP VA Gold 1500/20/Dental	KP VA Gold 1000/20/Dental
0–14	$231.86	$267.86	$308.97	$291.97	$287.63	$298.87	$289.17	$295.79
15	252.47	291.67	336.43	317.92	313.20	325.44	314.87	322.08
16	260.35	300.77	346.93	327.85	322.98	335.59	324.70	332.13
17	268.23	309.87	357.43	337.77	332.75	345.75	334.53	342.19
18	276.72	319.68	368.74	348.46	343.28	356.69	345.11	353.01
19	285.21	329.48	380.05	359.14	353.81	367.63	355.70	363.84
20	294.00	339.64	391.76	370.21	364.71	378.96	366.66	375.05
21	303.09	350.14	403.88	381.66	375.99	390.68	378.00	386.65
22	303.09	350.14	403.88	381.66	375.99	390.68	378.00	386.65
23	303.09	350.14	403.88	381.66	375.99	390.68	378.00	386.65
24	303.09	350.14	403.88	381.66	375.99	390.68	378.00	386.65
25	304.30	351.54	405.50	383.19	377.49	392.24	379.51	388.20
26	310.36	358.54	413.57	390.82	385.01	400.06	387.07	395.93
27	317.64	366.95	423.27	399.98	394.04	409.43	396.14	405.21
28	329.46	380.60	439.02	414.86	408.70	424.67	410.89	420.29
29	339.16	391.81	451.94	427.08	420.73	437.17	422.98	432.66
30	344.01	397.41	458.40	433.18	426.75	443.42	429.03	438.85
31	351.28	405.81	468.10	442.34	435.77	452.80	438.10	448.13
32	358.56	414.22	477.79	451.50	444.80	462.17	447.17	457.41
33	363.10	419.47	483.85	457.23	450.44	468.03	452.84	463.21
34	367.95	425.07	490.31	463.34	456.45	474.29	458.89	469.39
35	370.38	427.87	493.54	466.39	459.46	477.41	461.92	472.49
36	372.80	430.67	496.77	469.44	462.47	480.54	464.94	475.58
37	375.23	433.47	500.00	472.50	465.48	483.66	467.96	478.67
38	377.65	436.27	503.23	475.55	468.48	486.79	470.99	481.77
39	382.50	441.88	509.70	481.65	474.50	493.04	477.04	487.95
40	387.35	447.48	516.16	487.76	480.52	499.29	483.08	494.14
41	394.62	455.88	525.85	496.92	489.54	508.67	492.16	503.42
42	401.59	463.94	535.14	505.70	498.19	517.65	500.85	512.31
43	411.29	475.14	548.07	517.91	510.22	530.15	512.95	524.68
44	423.42	489.15	564.22	533.18	525.26	545.78	528.07	540.15
45	437.66	505.60	583.20	551.12	542.93	564.14	545.83	558.32
46	454.64	525.21	605.82	572.49	563.99	586.02	567.00	579.98
47	473.73	547.27	631.26	596.53	587.67	610.63	590.81	604.33
48	495.55	572.48	660.34	624.01	614.74	638.76	618.03	632.17
49	517.07	597.34	689.02	651.11	641.44	666.50	644.87	659.62
50	541.32	625.35	721.33	681.64	671.52	697.75	675.11	690.56
51	565.26	653.01	753.24	711.80	701.22	728.62	704.97	721.10
52	591.63	683.47	788.37	745.00	733.93	762.61	737.86	754.74
53	618.30	714.29	823.92	778.59	767.02	796.99	771.12	788.77
54	647.10	747.55	862.28	814.84	802.74	834.10	807.03	825.50
55	675.89	780.81	900.65	851.10	838.46	871.22	842.94	862.23
56	707.11	816.88	942.25	890.41	877.18	911.46	881.87	902.05
57	738.63	853.29	984.26	930.11	916.29	952.09	921.19	942.27
58	772.27	892.16	1029.09	972.47	958.02	995.45	963.14	985.18
59	788.94	911.41	1051.30	993.46	978.70	1016.94	983.93	1006.45
60	822.59	950.28	1096.13	1035.83	1020.44	1060.31	1025.89	1049.37
61	851.68	983.89	1134.90	1072.46	1056.53	1097.81	1062.18	1086.49
62	870.78	1005.95	1160.35	1096.51	1080.22	1122.42	1085.99	1110.85
63	894.72	1033.61	1192.25	1126.66	1109.92	1153.29	1115.86	1141.39
64+	909.27	1050.42	1211.64	1144.98	1127.97	1172.04	1134.00	1159.95

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

2018 Non-tobacco monthly rates

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

Age on 2018 effective date	KP VA Gold 0/20/ Dental	KP VA Platinum 0/5/Dental	KP VA Catastrophic 7350/0/Dental	KP VA Silver 3500/30/CSR/ Dental (6000) KP VA Silver 0/15/ CSR/Dental (6000) KP VA Silver 0/5/ CSR/Dental (6000)	KP VA Standard Silver 3000/30/ CSR/Dental (3500) KP VA Standard Silver 700/10/CSR/ Dental (3500) KP VA Standard Silver 250/5/CSR/ Dental (3500)	KP VA Silver 1700/20%/CSR/ HDHP/Dental (2750) KP VA Silver 500/10%/CSR/ HDHP/Dental (2750) KP VA Silver 100/5%/CSR/HDHP/ Dental (2750)	KP VA Silver 1750/30/CSR/ Dental (2000) KP VA Silver 0/10/ CSR/Dental (2000) KP VA Silver 0/5/ CSR/Dental (2000)	KP VA Silver 1750/30/CSR/ Dental (3000) KP VA Silver 0/10/ CSR/Dental (3000) KP VA Silver 0/5/ CSR/Dental (3000)
0–14	$304.38	$346.45	$176.55	$267.86	$308.97	$287.63	$298.87	$291.97
15	331.43	377.24	192.25	291.67	336.43	313.20	325.44	317.92
16	341.78	389.02	198.25	300.77	346.93	322.98	335.59	327.85
17	352.12	400.79	204.25	309.87	357.43	332.75	345.75	337.77
18	363.26	413.47	210.71	319.68	368.74	343.28	356.69	348.46
19	374.41	426.15	217.17	329.48	380.05	353.81	367.63	359.14
20	385.94	439.28	223.87	339.64	391.76	364.71	378.96	370.21
21	397.88	452.87	230.79	350.14	403.88	375.99	390.68	381.66
22	397.88	452.87	230.79	350.14	403.88	375.99	390.68	381.66
23	397.88	452.87	230.79	350.14	403.88	375.99	390.68	381.66
24	397.88	452.87	230.79	350.14	403.88	375.99	390.68	381.66
25	399.47	454.68	231.71	351.54	405.50	377.49	392.24	383.19
26	407.43	463.74	236.33	358.54	413.57	385.01	400.06	390.82
27	416.98	474.61	241.87	366.95	423.27	394.04	409.43	399.98
28	432.50	492.27	250.87	380.60	439.02	408.70	424.67	414.86
29	445.23	506.76	258.25	391.81	451.94	420.73	437.17	427.08
30	451.59	514.01	261.95	397.41	458.40	426.75	443.42	433.18
31	461.14	524.88	267.49	405.81	468.10	435.77	452.80	442.34
32	470.69	535.75	273.02	414.22	477.79	444.80	462.17	451.50
33	476.66	542.54	276.49	419.47	483.85	450.44	468.03	457.23
34	483.03	549.78	280.18	425.07	490.31	456.45	474.29	463.34
35	486.21	553.41	282.03	427.87	493.54	459.46	477.41	466.39
36	489.39	557.03	283.87	430.67	496.77	462.47	480.54	469.44
37	492.58	560.65	285.72	433.47	500.00	465.48	483.66	472.50
38	495.76	564.28	287.56	436.27	503.23	468.48	486.79	475.55
39	502.12	571.52	291.26	441.88	509.70	474.50	493.04	481.65
40	508.49	578.77	294.95	447.48	516.16	480.52	499.29	487.76
41	518.04	589.64	300.49	455.88	525.85	489.54	508.67	496.92
42	527.19	600.05	305.80	463.94	535.14	498.19	517.65	505.70
43	539.92	614.54	313.18	475.14	548.07	510.22	530.15	517.91
44	555.84	632.66	322.41	489.15	564.22	525.26	545.78	533.18
45	574.54	653.94	333.26	505.60	583.20	542.93	564.14	551.12
46	596.82	679.31	346.19	525.21	605.82	563.99	586.02	572.49
47	621.89	707.84	360.72	547.27	631.26	587.67	610.63	596.53
48	650.53	740.44	377.34	572.48	660.34	614.74	638.76	624.01
49	678.78	772.60	393.73	597.34	689.02	641.44	666.50	651.11
50	710.61	808.83	412.19	625.35	721.33	671.52	697.75	681.64
51	742.05	844.60	430.42	653.01	753.24	701.22	728.62	711.80
52	776.66	884.00	450.50	683.47	788.37	733.93	762.61	745.00
53	811.68	923.85	470.81	714.29	823.92	767.02	796.99	778.59
54	849.47	966.88	492.74	747.55	862.28	802.74	834.10	814.84
55	887.27	1009.90	514.66	780.81	900.65	838.46	871.22	851.10
56	928.25	1056.55	538.43	816.88	942.25	877.18	911.46	890.41
57	969.63	1103.64	562.44	853.29	984.26	916.29	952.09	930.11
58	1013.80	1153.91	588.05	892.16	1029.09	958.02	995.45	972.47
59	1035.68	1178.82	600.75	911.41	1051.30	978.70	1016.94	993.46
60	1079.85	1229.09	626.36	950.28	1096.13	1020.44	1060.31	1035.83
61	1118.04	1272.56	648.52	983.89	1134.90	1056.53	1097.81	1072.46
62	1143.11	1301.10	663.06	1005.95	1160.35	1080.22	1122.42	1096.51
63	1174.54	1336.87	681.29	1033.61	1192.25	1109.92	1153.29	1126.66
64+	1193.64	1358.61	692.37	1050.42	1211.64	1127.97	1172.04	1144.98

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.

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

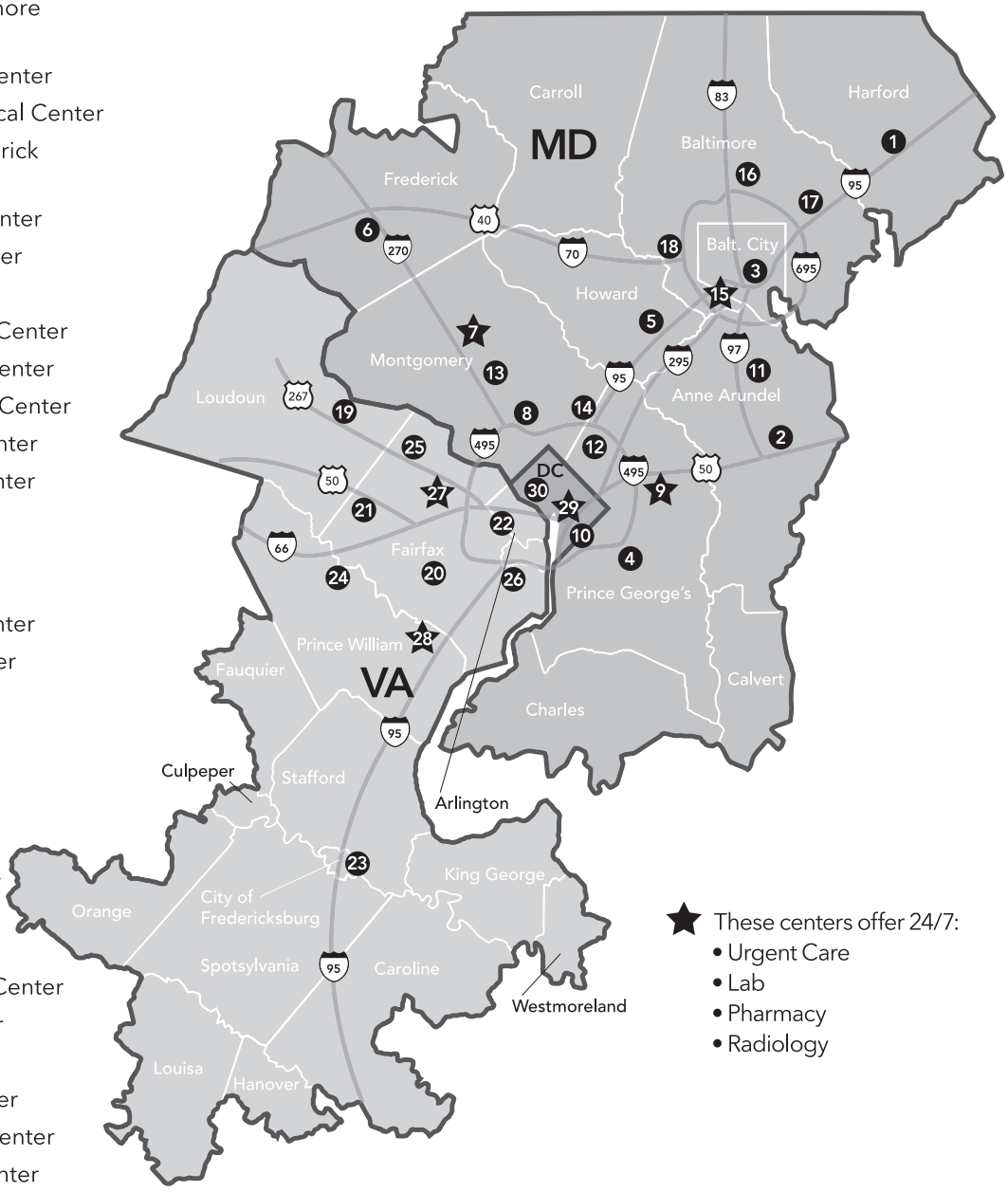
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Camp Springs Medical Center
5 Columbia Gateway Medical Center
6 Kaiser Permanente Frederick Medical Center
7 Gaithersburg Medical Center
8 Kensington Medical Center
9 Largo Medical Center
10 Marlow 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.

Important details and notices

Notice of insurance information practices – Abbreviated version

Virginia

Please be advised that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter Kaiser Permanente), has not received any personal information regarding your application from any person other than the applicant. Personal information necessary to determine eligibility for coverage may be collected from the application.

Please also be assured that it is Kaiser Permanente's policy to protect the confidentiality of your private medical information to the full extent of the law.

Kaiser Permanente will not disclose any personal or privileged information about an individual that is collected or received unless the disclosure is:

- authorized in writing by the individual; or
- made to a medical care institution or medical professional for the purpose of:
  - verifying insurance coverage or benefits, or
  - informing an individual of a medical problem of which the individual may not be aware, or
  - conducting an operations or services audit, provided that information is disclosed only as is reasonably necessary to accomplish the foregoing purposes; or
- made to an insurance regulatory authority; or
- made to a law enforcement or other government authority to protect Kaiser Permanente interests in preventing or prosecuting the perpetration of fraud upon it; or
- as permitted by applicable law.

You have the right to see and obtain copies of the recorded personal information pertaining to you by submitting a written request. If you ask us to correct, amend, or delete any information about you in our files and if we refuse to do so, you have the right to give us a concise statement of what you believe is the correct information and we will put your statement in our file so that anyone reviewing it will see it.

Information obtained from a report prepared by an insurance-support organization may be retained by an insurance-support organization and disclosed to other persons.

This is an abbreviated version of the notice of information collection and disclosure practices. Kaiser Permanente's complete *Notice of Insurance Information Practices* form is available to you upon request.

Exclusions, limitations and coordination of benefits

This section provides you with information on what Services Health Plan will not pay for regardless of whether or not the Service is Medically Necessary. It also provides information on how your benefits may be reduced as the result of other types of coverage.

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this Agreement. Additional exclusions that apply only to a particular Service are listed in the description of that Service in Section 3. When a Service is excluded, all Services directly related to the excluded Service are also excluded, even if they would otherwise be covered under this Agreement. Services that are not Medically Necessary are also excluded.

Alternative Medical Services

- Acupuncture
- Holistic medicine
- Homeopathic medicine
- Hypnosis
- Aroma therapy
- Massage and massage therapy
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Naturopathy
- Thermography
- Orthomolecular therapy
- Contact reflex analysis
- Bioenergial synchronization technique (BEST)
- Iridology-study of the iris
- Auditory integration therapy (AIT)
- Colonic irrigation
- Magnetic innervation therapy
- Electromagnetic therapy
- Neurofeedback/Biofeedback

Certain Exams and Services

Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance, licensing, or disability determination, or (c) on court-order or required for parole or probation.

Cosmetic Services

Cosmetic Services, including surgery or related 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.

Court Ordered Testing

Court ordered testing or care unless Medically Necessary

Custodial Care

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

Dental Care

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

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

Disposable Supplies

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices, not specifically listed as covered in Section 3.

Durable Medical Equipment

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

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Non-medical items such as sauna baths or elevators;
- Hydrotherapy equipment;
- Modifications to your home or car; and
- Electronic monitors of the heart or lungs, except infant apnea monitors

Employer or Government Responsibility

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

Experimental or Investigational Services

Except as covered under "Clinical Trials" in Section 3, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:

- It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

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

- your medical records,
- the written protocols or other documents pursuant to which the Service has been or will be provided,
- any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- the published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury, and
- regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

Prosthetic and Orthotic Devices

Prosthetics for sports or cosmetic purposes. Services and supplies for external prosthetic and orthothic devices, except as specifically covered under Section 3 of this Agreement.

Routine Foot Care Services

Except for patients with diabetes or vascular disease as specifically covered under Section 3, the following foot care Services (palliative or cosmetic) are excluded:

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

Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations, if a Plan Physicians refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in Section 2: How to Obtain Services, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

Workers' Compensation or Employer's Liability

Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
- You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

Limitations

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, terrorist activity, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Center, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services.

In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone elective care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences. Emergency and urgent care Services will be provided as described under "Getting Urgent and Emergency Services" in Section 2, and under "Urgent Care Service" and "Emergency Services" in Section 3.

Coordination of benefits

TRICARE and Medicare Benefits

The value of your benefits are coordinated with any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are secondary benefits by law.

Coordination of Benefits (COB)

The Plan that pays first (Primary Plan) is determined by using National Association of Insurance Commissioners (NAIC) and Medicare Secondary Payer (MSP) Order of Benefits Guidelines.

The Primary Plan provides benefits as it would in the absence of any other coverage. The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or Service provided, and the maximum liability of the Secondary Plan, not to exceed 100 percent of total Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

The following COB rules for Health Plan are modeled after the rules recommended by the National Association of Insurance Commissioners (NAIC) and the Medicare Secondary Payor rules, which are incorporated by reference.

You must give us any information we request to help us coordinate benefits. If you have any questions about COB, please call our Member Services Call Center.

Inside the Washington, D.C. Metropolitan area:
(301) 468-6000

Outside the Washington, D.C. Metropolitan area:
1-800-777-7902

TTY: **711**

Coordination of Benefits Rules

Coordination of Benefits ("COB") applies when a Member has health care coverage under more than one Plan. "Plan" and "Health Plan" are defined below.

The Order of Benefit Determination Rules will be used to determine which Plan is the Primary Plan. The other Plans will be Secondary Plan(s). If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering the other Plan(s) benefits. If the Health Plan is a Secondary Plan, the benefits or services provided under this Agreement will be coordinated with the Primary Plan so the total of benefits paid, or the reasonable cash value of the services provided, between the Primary Plan and the Secondary Plan(s) do not exceed 100% of the total Allowable Expense.

Definitions

Plan: Any of the following that provides benefits or services for, or because of, medical care or treatment:

Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. "Plan" does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis.

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

Allowable Expense: a health care Service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare Service or a portion of an expense or health care Service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the Section 3.

Claim Determination Period: A calendar year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1) If another Plan does not have a COB provision, that Plan is the Primary Plan.

2) If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:

- **Subscriber /Dependent.** A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
- **Dependent Child/Parents Not Separated or Divorced.** When Health Plan and another Plan cover the same child as a Dependent of different persons, called "parents": (i) the Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; or (ii) if both parents have the same birthday, the Plan that covered a parent longer is Primary; or (iii) if the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.
- **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (i) first, the Plan of the parent with custody of the child; (ii) then, the Plan of the spouse of the parent with custody of the child; and (iii) finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.
- Active/Inactive Employee. A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's dependent).
- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

Effect of COB on the Benefits of this Plan

When Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of services provided by Health Plan. At the Member's request, Health Plan will provide or arrange for covered services and then seek coordination with a Primary Plan.

Coordination with Health Plan's Benefits.

Health Plan may coordinate benefits payable or may recover the reasonable cash value of services it has provided when the sum of the benefits that would be payable for, or the reasonable cash value of, the services provided as Allowable Expenses by Health Plan in the absence of this COB provision and the benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.

Right to Reserve and Release Needed Information

Certain information is needed to apply these COB rules. Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.

Facility of Payment

If a payment made or Service provided under another Plan includes an amount that should have been paid or provided by or through Health Plan, Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it was a benefit paid by Health Plan.

Right of Recovery

If the amount of payment by Health Plan is more than it should have been under this COB provision, or if Health Plan has provided services that should have been paid by the Primary Plan, Health Plan may recover the excess or the reasonable cash value of the services, as applicable, from the person who received payment or for whom payment was made; or from an insurance company or other organization.

Benefit Reserve Account

When Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from Health Plan's Patient Accounting Department.

Military Service

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

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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Already a member?
Manage your care online anytime at kp.org. If you haven't already, go to **kp.org/registernow** so you can start emailing your doctor's office with nonurgent questions, schedule routine appointments, order most prescription refills, and more.

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Having a good health plan is important. So is getting quality care. With Kaiser Permanente, you get both.

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Visit **kp.org/thrive** or call us at **1-800-494-5314.** (For TTY, call **711.**)

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