KAISER PERMANENTE®

Kaiser Permanente for Individuals and Families

Healthy together

Care and coverage that fits your life

buykp.org

2019 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 nonurgent 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.

*When appropriate and available.

†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 2019 coverage runs from **November 1, 2018, through December 15, 2018.** 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, 2019, we must receive your Application for Health Coverage and first month's premium **no later than December 15, 2018.**

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 qualifying life event.

Visit **kp.org/specialenrollment** for a list of qualifying life events and instructions.

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	Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face online. Call us or email your doctor's office to see if video visits are available to you.*
Phone	Have a condition that doesn't require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente doctor.
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.

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 premium is higher, but you'll pay much less when you actually get care.

Deductible plans

Gold, Silver, Bronze

With a deductible plan, your monthly premium 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.

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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*
KP MD Silver 2500/30/Dental/Off ($2,500 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.

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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 MD Silver 2500/30/Dental/Off KP MD Silver 2500/30/Dental
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$7,750/$15,500
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 pharmacy deductible per member*
Non-preferred brand	35% after $750 pharmacy deductible per member
Specialty	35% after $750 pharmacy 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 $2,500 for yourself or $5,000 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 $7,750 for yourself and no more than $15,500 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.

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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 6000/50/Dental	KP M KP MD Bronze 6200/20%/HSA/Dental	KP M KP MD Silver 6000/35/ Dental/Off KP MD Silver 6000/35/Dental	KP M KP MD Silver 3200/20%/HSA/ Dental/Off KP MD Silver 3200/20%/HSA/Dental
Plan type	**Deductible**	**HSA-qualified**	**Deductible**	**HSA-qualified**
Features				
Annual medical deductible (individual/family)	$6,000/$12,000	$6,200/$12,400	$6,000/$12,000	$3,200/$6,400
Annual out-of-pocket maximum (individual/family)	$7,900/$15,800	$6,550/$13,100	$7,900/$15,800	$6,000/$12,000
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	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	$35 (waived for children under 5)	20% after deductible
Specialty care office visit	40% after deductible	20% after deductible	$55	20% after deductible
Most X-rays	40% after deductible	20% after deductible	$50	20% after deductible
Most lab tests	40% after deductible	20% after deductible	$35	20% after deductible
MRI, CT, PET	40% after deductible	20% after deductible	35% after deductible	20% after deductible
Outpatient surgery	40% after deductible	20% after deductible	35% after deductible	20% after deductible
Mental health visit	40% after deductible	20% after deductible	$35 (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	20% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	20% after deductible	35% after deductible	20% after deductible
Emergency and urgent care				
Emergency Department visit	40% after deductible	20% after deductible	35% after deductible	20% after deductible
Urgent care visit	40% after deductible	20% after deductible	$55	20% after deductible
Prescription drugs (up to a 30-day supply)				
Generic	40% after deductible	$20 after deductible†	$20†	$15 after deductible†
Preferred brand	40% after deductible	50% after deductible	$60 after $750 pharmacy deductible per member†	$55 after deductible†
Non-preferred brand	40% after deductible	50% after deductible	35% after $750 pharmacy 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	35% after $750 pharmacy 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)

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 complete 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 **301-468-6000**, 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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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 2500/30/Dental/Off KP MD Silver 2500/30/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‡ 7900/0/Dental
Plan type	**Deductible**	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features						
Annual medical deductible (individual/family)	$2,500/$5,000	$1,500/$3,000	$1,000/$2,000	None/None	None/None	$7,900/$15,800
Annual out-of-pocket maximum (individual/family)	$7,750/$15,500	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$4,000/$8,000	$7,900/$15,800
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	35% after deductible	$500	$500	$150	No charge after deductible
Outpatient surgery	35% after deductible	35% after deductible	35% after deductible	35%	$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	35% after deductible	35% after deductible	35%	$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	35% after deductible	35% after deductible	30%	$350 per day up to 4 days*	No charge after deductible
Emergency and urgent care						
Emergency Department visit	35% after deductible	35% 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 pharmacy deductible per member†	$30 after $200 pharmacy deductible per member†	$30†	$30†	$30†	No charge after deductible
Non-preferred brand	35% after $750 pharmacy deductible per member	30% after $200 pharmacy deductible per member	35%	35%	$50†	No charge after deductible
Specialty	35% after $750 pharmacy deductible per member up to $150 maximum per 30-day prescription	30% after $200 pharmacy deductible per member up to $150 maximum per 30 day prescription	35% up to $150 maximum per 30-day prescription	35% 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)

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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.

‡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 7900/0/Dental plan.

**The KP MD Catastrophic 7900/0/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 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 (3200)	M KP MD Silver 500/10%/CSR/ HDHP/Dental (3200)	M KP MD Silver 100/5%/CSR/ HDHP/Dental (3200)
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)	$6,300/$12,600	$2,600/$5,200	$2,000/$4,000	$6,000/$12,000	$2,250/$4,500	$2,250/$4,500
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 after $250 deductible†	$55†	$10†	$55 after deductible†	$35 after deductible†	$10 after deductible†
Non-preferred brand	35% after $250 deductible	30%	10%	20% after deductible	10% after deductible	5% after deductible
Specialty	35% up to $150 maximum after $250 deductible 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.

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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 2200/30/CSR/Dental (2500)	M KP MD Silver 0/10/CSR/Dental (2500)	M KP MD Silver 0/5/CSR/Dental (2500)
Plan type	**Deductible**	**Copayment**	**Copayment**
Features			
Annual medical deductible (individual/family)	$2,200/$4,400	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,300/$12,600	$2,600/$5,200	$1,800/$3,600
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	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)
Specialty care office visit	$50	$20	$5
Most X-rays	$50	$30	$10
Most lab tests	$30	$20	$5
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	$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%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%
Emergency and urgent care			
Emergency Department visit	35% after deductible	30%	10%
Urgent care visit	$50	$20	$5
Prescription drugs (up to a 30-day supply)			
Generic	$15†	$10†	$5†
Preferred brand	$55 after $750 pharmacy deductible per member†	$50†	$10†
Non-preferred brand	35% after $750 pharmacy deductible per member	30%	10%
Specialty	35% after $750 pharmacy 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)

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 complete 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 **301-468-6000**, 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.

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	20781–85	20918	21108	21284–87
20601–04	20787–88	20993	21111	21289–90
20607–08	20790–92	20997	21113–14	21297–98
20610	20794	21001	21117	21401–05
20612–13	20797	21005	21120	21409
20616–17	20799	21009–10	21122–23	21411–12
20623	20810–18	21012–15	21128	21701–05
20637	20824–25	21017–18	21130–33	21709–10
20639–40	20827	21020	21136	21714
20643	20830	21022–23	21139–40	21716–18
20645–46	20832–33	21027–32	21144	21723
20658	20837–39	21034–37	21146	21737–38
20675	20841–42	21040–48	21150	21754–55
20677–78	20847–55	21050–54	21152–58	21757–59
20689	20857	21056–57	21160–63	21762
20695	20859–62	21060–62	21201–31	21765
20697	20866	21065	21233–37	21769–71
20701	20868	21071	21239–41	21774–77
20703–12	20871–72	21074–78	21244	21784
20714–26	20874–80	21082	21250–52	21787
20731–33	20882–86	21084–85	21263–64	21790–94
20735–38	20889	21087–88	21270	21797
20740–55	20891–92	21090	21273	
20757–59	20894–99	21092–94	21275	
20762–65	20901–08	21102	21278–79	
20768–79	20910–16	21104–06	21281–82	

KAISER PERMANENTE®

2019 Monthly rates

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

Age on 2019 effective date	KP MD Bronze 6000/50/Dental	KP MD Bronze 6200/20%/HSA/ Dental	KP MD Silver 6000/35/Dental/Off	KP MD Silver 3200/20%/HSA/ Dental/Off	KP MD Silver 2500/30/ Dental/Off	KP MD Gold 0/20/ Dental	KP MD Bronze 6000/50/Dental
0–14	$194.07	$178.67	$208.88	$216.63	$227.01	$255.48	$194.07
15	211.32	194.55	227.44	235.88	247.19	278.19	211.32
16	217.92	200.62	234.54	243.24	254.91	286.87	217.92
17	224.52	206.69	241.64	250.61	262.62	295.55	224.52
18	231.62	213.23	249.29	258.53	270.93	304.91	231.62
19	238.72	219.77	256.93	266.46	279.24	314.26	238.72
20	246.08	226.54	264.85	274.67	287.85	323.94	246.08
21	253.69	233.55	273.04	283.17	296.75	333.96	253.69
22	253.69	233.55	273.04	283.17	296.75	333.96	253.69
23	253.69	233.55	273.04	283.17	296.75	333.96	253.69
24	253.69	233.55	273.04	283.17	296.75	333.96	253.69
25	254.70	234.48	274.13	284.30	297.94	335.30	254.70
26	259.78	239.16	279.59	289.97	303.87	341.98	259.78
27	265.87	244.76	286.15	296.76	310.99	349.99	265.87
28	275.76	253.87	296.79	307.81	322.57	363.01	275.76
29	283.88	261.34	305.53	316.87	332.06	373.70	283.88
30	287.94	265.08	309.90	321.40	336.81	379.04	287.94
31	294.03	270.68	316.45	328.19	343.93	387.06	294.03
32	300.12	276.29	323.01	334.99	351.06	395.07	300.12
33	303.92	279.79	327.10	339.24	355.51	400.08	303.92
34	307.98	283.53	331.47	343.77	360.25	405.43	307.98
35	310.01	285.40	333.65	346.03	362.63	408.10	310.01
36	312.04	287.27	335.84	348.30	365.00	410.77	312.04
37	314.07	289.13	338.02	350.56	367.38	413.44	314.07
38	316.10	291.00	340.21	352.83	369.75	416.11	316.10
39	320.16	294.74	344.58	357.36	374.50	421.46	320.16
40	324.22	298.48	348.95	361.89	379.25	426.80	324.22
41	330.30	304.08	355.50	368.69	386.37	434.82	330.30
42	336.14	309.45	361.78	375.20	393.19	442.50	336.14
43	344.26	316.93	370.52	384.26	402.69	453.18	344.26
44	354.40	326.27	381.44	395.59	414.56	466.54	354.40
45	366.33	337.25	394.27	408.90	428.51	482.24	366.33
46	380.54	350.33	409.56	424.76	445.13	500.94	380.54
47	396.52	365.04	426.76	442.59	463.82	521.98	396.52
48	414.78	381.85	446.42	462.98	485.19	546.02	414.78
49	432.80	398.44	465.81	483.09	506.26	569.74	432.80
50	453.09	417.12	487.65	505.74	530.00	596.45	453.09
51	473.13	435.57	509.22	528.11	553.44	622.84	473.13
52	495.20	455.89	532.97	552.75	579.26	651.89	495.20
53	517.53	476.44	557.00	577.67	605.37	681.28	517.53
54	541.63	498.63	582.94	604.57	633.56	713.00	541.63
55	565.73	520.82	608.88	631.47	661.75	744.73	565.73
56	591.86	544.87	637.00	660.64	692.32	779.13	591.86
57	618.24	569.16	665.40	690.09	723.18	813.86	618.24
58	646.40	595.09	695.71	721.52	756.12	850.93	646.40
59	660.36	607.93	710.72	737.09	772.44	869.30	660.36
60	688.51	633.85	741.03	768.52	805.38	906.37	688.51
61	712.87	656.28	767.24	795.71	833.87	938.43	712.87
62	728.85	670.99	784.44	813.55	852.56	959.47	728.85
63	748.89	689.44	806.01	835.92	876.01	985.85	748.89
64+	761.07	700.65	819.12	849.51	890.25	1,001.88	761.07

Rates are effective January 1, 2019, through December 31, 2019.

KAISER PERMANENTE®

2019 Monthly rates

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

Age on 2019 effective date	KP MD Silver 6000/35/Dental KP MD Silver 0/15/ CSR/Dental (6000) KP MD Silver 3500/30/CSR/Dental (6000) KP MD Silver 0/5/ CSR/Dental (6000)	KP MD Silver 3200/20%/HSA/ Dental KP MD Silver 100/5%/CSR/HDHP/ Dental (3200) KP MD Silver 500/10%/CSR/ HDHP/Dental (3200) KP MD Silver 1700/20%/CSR/ HDHP/Dental (3200)	KP MD Silver 2500/30/Dental KP MD Silver 2200/30/CSR/ Dental (2500) KP MD Silver 0/5/ CSR/Dental (2500) KP MD Silver 0/10/ CSR/Dental (2500)	KP MD Gold 1500/20/Dental	KP MD Gold 1000/20/Dental	KP MD Gold 0/20/Dental	KP MD Platinum 0/5/Dental	KP MD Catastrophic 7900/0/Dental
0–14	$241.93	$250.90	$262.94	$244.26	$247.57	$255.48	$285.74	$166.27
15	263.44	273.21	286.31	265.97	269.58	278.19	311.14	181.05
16	271.66	281.73	295.25	274.27	277.99	286.87	320.85	186.70
17	279.88	290.26	304.18	282.57	286.40	295.55	330.57	192.35
18	288.74	299.45	313.81	291.51	295.47	304.91	341.02	198.44
19	297.59	308.63	323.43	300.45	304.53	314.26	351.48	204.53
20	306.76	318.14	333.40	309.71	313.91	323.94	362.31	210.83
21	316.25	327.98	343.71	319.29	323.62	333.96	373.52	217.35
22	316.25	327.98	343.71	319.29	323.62	333.96	373.52	217.35
23	316.25	327.98	343.71	319.29	323.62	333.96	373.52	217.35
24	316.25	327.98	343.71	319.29	323.62	333.96	373.52	217.35
25	317.52	329.29	345.08	320.57	324.91	335.30	375.01	218.22
26	323.84	335.85	351.96	326.95	331.39	341.98	382.48	222.57
27	331.43	343.72	360.21	334.62	339.15	349.99	391.45	227.78
28	343.76	356.51	373.61	347.07	351.77	363.01	406.02	236.26
29	353.88	367.01	384.61	357.29	362.13	373.70	417.97	243.21
30	358.94	372.26	390.11	362.39	367.31	379.04	423.95	246.69
31	366.53	380.13	398.36	370.06	375.08	387.06	432.91	251.91
32	374.12	388.00	406.61	377.72	382.84	395.07	441.87	257.13
33	378.87	392.92	411.76	382.51	387.70	400.08	447.48	260.39
34	383.93	398.17	417.26	387.62	392.87	405.43	453.45	263.86
35	386.46	400.79	420.01	390.17	395.46	408.10	456.44	265.60
36	388.99	403.42	422.76	392.73	398.05	410.77	459.43	267.34
37	391.52	406.04	425.51	395.28	400.64	413.44	462.42	269.08
38	394.05	408.66	428.26	397.84	403.23	416.11	465.41	270.82
39	399.11	413.91	433.76	402.94	408.41	421.46	471.38	274.30
40	404.17	419.16	439.26	408.05	413.59	426.80	477.36	277.77
41	411.76	427.03	447.51	415.72	421.35	434.82	486.32	282.99
42	419.03	434.57	455.42	423.06	428.80	442.50	494.91	287.99
43	429.15	445.07	466.41	433.28	439.15	453.18	506.87	294.94
44	441.80	458.19	480.16	446.05	452.10	466.54	521.81	303.64
45	456.67	473.60	496.32	461.05	467.31	482.24	539.36	313.85
46	474.38	491.97	515.57	478.94	485.43	500.94	560.28	326.03
47	494.30	512.63	537.22	499.05	505.82	521.98	583.81	339.72
48	517.07	536.25	561.97	522.04	529.12	546.02	610.71	355.37
49	539.52	559.53	586.37	544.71	552.10	569.74	637.23	370.80
50	564.82	585.77	613.87	570.25	577.99	596.45	667.11	388.19
51	589.81	611.68	641.02	595.48	603.55	622.84	696.61	405.36
52	617.32	640.22	670.92	623.25	631.71	651.89	729.11	424.27
53	645.15	669.08	701.17	651.35	660.18	681.28	761.98	443.39
54	675.19	700.24	733.82	681.68	690.93	713.00	797.47	464.04
55	705.24	731.40	766.47	712.02	721.67	744.73	832.95	484.69
56	737.81	765.18	801.88	744.90	755.01	779.13	871.42	507.08
57	770.70	799.29	837.62	778.11	788.66	813.86	910.27	529.68
58	805.81	835.69	875.77	813.55	824.58	850.93	951.73	553.81
59	823.20	853.73	894.68	831.11	842.38	869.30	972.27	565.76
60	858.30	890.14	932.83	866.55	878.30	906.37	1,013.73	589.89
61	888.66	921.62	965.83	897.20	909.37	938.43	1,049.59	610.75
62	908.59	942.29	987.48	917.32	929.76	959.47	1,073.12	624.45
63	933.57	968.20	1,014.63	942.54	955.33	985.85	1,102.63	641.62
64+	948.75	983.94	1,031.13	957.87	970.86	1,001.88	1,120.56	652.05

Rates are effective January 1, 2019, through December 31, 2019.

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 **855-733-7524.**

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.

61020308 MD 2019

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

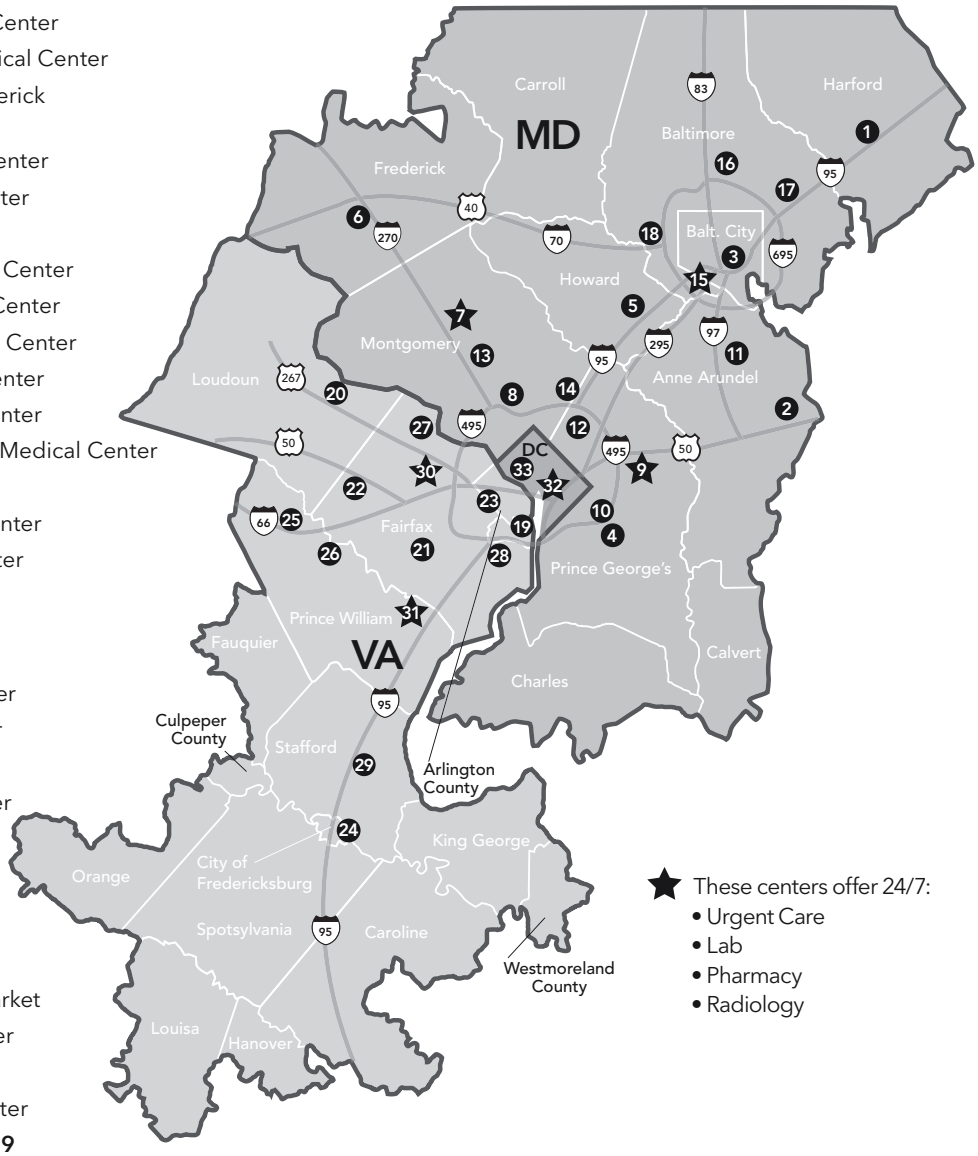
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Camp Springs Medical Center
5 Columbia Gateway Medical Center
6 Kaiser Permanente Frederick Medical Center
7 Gaithersburg Medical Center
8 Kensington Medical Center
9 Largo Medical Center
10 Marlow 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 **OPENING SPRING 2019** Alexandria Medical Center
20 Ashburn Medical Center
21 Burke Medical Center
22 Fair Oaks Medical Center
23 Falls Church Medical Center
24 Fredericksburg Medical Center
25 **OPENING LATE 2019** Medical Center at Haymarket
26 Manassas Medical Center
27 Reston Medical Center
28 Springfield Medical Center
29 **OPENING SUMMER 2019** Medical Center at Stafford
30 Tysons Corner Medical Center
31 Woodbridge Medical Center

Washington, D.C.

32 Kaiser Permanente Capitol Hill Medical Center
33 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.

You must receive all covered Services from Plan Providers inside our Service Area 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.

Anesthesia for Dental Care

Benefit-Specific Exclusions:
The dentist or specialist's dental care Services.

Bone Mass Measurement

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.

Chiropractic Services

Benefit-Specific Limitations:

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

Clinical Trials

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.

Family Planning Services

Benefit-Specific Exclusions:

Services:

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

Habilitative Services for Adults

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.

Habilitative Services for Children

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.

Hearing Services

Benefit-Specific Exclusions:

Replacement batteries to power hearing aids are not covered.

Infertility Services

Benefit-Specific Limitations:

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

Benefit-Specific Exclusions:

1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts;
2. Any charges associated with donor eggs, donor sperm or donor embryos;
3. Infertility Services, except for covered Services for in vitro fertilization (IVF), when the Member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists;
4. Services to reverse voluntary, surgically induced infertility;
5. Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure;

6. Assisted reproductive technologies and procedures, other than those described above: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

Mental Health and Substance Abuse Services

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.

Oral Surgery/Temporomandibular Joint Services (TMJ)

Benefit-Specific Exclusions:

1. Lab fees associated with cysts that are considered dental under our standards.
2. Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
3. Orthodontic Services.
4. Fixed or removable appliances that involve movement or repositioning of the teeth.
5. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident.

Routine Foot Care

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.

Skilled Nursing Facility Services

Benefit-Specific Limitations:

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

Telemedicine 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.

Therapy and Rehabilitation Services

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.

Urgent Care Services

Benefit-Specific Limitations:

1. We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for ESRD, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Benefit-Specific Exclusions:

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

Exclusions

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

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section. When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service. 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 ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) 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**).

NOTES

NOTES

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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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