Find your healthy place

With care designed to help you thrive

Welcome to care that fits your life

This Kaiser Permanente for Individuals and Families enrollment guide can help you choose the right health plan for your needs. Here's a look at what you'll get with all of our plans.

Get care on your schedule

Need to schedule an appointment or have a nonurgent question for your doctor's office? Want your prescription refill mailed to your home? After you enroll, create your online account at kp.org or get our mobile app. Then join millions of members who manage their health online – whenever, wherever.

Connect to care from anywhere

Want a convenient, secure way to get care from wherever you are? Schedule a call with a Kaiser Permanente clinician, meet face-to-face online, or email your doctor's office anytime with nonurgent health questions.*,†

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. Find a location near you at **kp.org/facilities**.

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.

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**.

*When appropriate and available. †These features are available when you get care at Kaiser Permanente facilities.

533337762 District of Columbia 2021

Choosing your health plan

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.

Copay plans – platinum and 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 get care.

Deductible plans – Gold, Silver, Bronze, Catastrophic

With a deductible plan, your monthly premium is lower, but you'll need to pay the full charges for most covered services until you reach a set amount, known as your deductible. Then you'll start paying less – 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 reach your deductible.

HSA-qualified high deductible health plans – silver and bronze

HSA-qualified high deductible health plans (HDHPs) 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, like eyeglasses, adult dental care, or chiropractic services.* 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.

Example of your costs for care

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

Plan name	Office visit	X-ray	Generic drug
KP DC Gold 0/20/Vision (no deductible)	$20 (waived for children under age 5)	$65	$15*
KP DC Silver 2500/30/Vision ($2,500 deductible)	$30 (waived for children under age 5)	$70	$20*
KP DC Standard Bronze 6350/20%/HSA/Vision ($6,350 deductible)	20% after deductible	20% after deductible	20% after deductible

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

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

Important open enrollment dates for 2021

- The open enrollment period for 2021 coverage runs from November 1, 2020, through January 31, 2021.
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through DC Health Link.
- For coverage that starts on January 1, 2021, we must receive your Application for Health Coverage and first month's premium no later than December 15, 2020.

Enrolling during a special enrollment period

- Are you getting married, moving to a Kaiser Permanente service area, or losing your health coverage? You can also enroll or change your coverage at other times throughout the year if you have a qualifying life event.
- Visit **kp.org/specialenrollment** for a list of qualifying life events and instructions.

Do you qualify for financial help?

You may be eligible for federal or state financial assistance to help you pay for care or coverage. Visit **dchealthlink.com** for details.

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 DC Silver 2500/30/Vision
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$8,250/$16,500
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	$60
Most X-rays	$70
Most lab tests	$40
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	$60
Prescription drugs (up to a 30-day supply)	
Generic	$20*
Preferred brand	$60 after $800 pharmacy deductible per member*
Non-preferred brand	35% after $800 pharmacy deductible per member
Specialty	35% after $800 pharmacy deductible per member up to $150 maximum per 30-day prescription
Whole health	
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.

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 $8,250 for yourself and no more than $16,500 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 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 $60 copay for urgent care visits, whether or not you have met your deductible.

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

	KP DC Standard Bronze 7500/60/ Vision	KP DC Bronze 6500/65/Vision	KP DC Standard Bronze 6350/20%/ HSA/Vision	KP DC Standard Silver 4000/40/ Vision	KP DC Silver 3200/30%/HSA/ Vision	KP DC Silver 2500/30/Vision
Plan type	**Deductible**	**Deductible**	**HSA-qualified**	**Deductible**	**HSA-qualified**	**Deductible**
Features						
Annual medical deductible (individual/family)	$7,500/$15,000	$6,500/$13,000	$6,350/$12,700	$4,000/$8,000	$3,200/$6,400	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$8,550/$17,100	$8,550/17,100	$6,900/$13,800	$8,250/$16,500	$6,650/$13,300	$8,250/$16,500
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	$60	$65 (waived for children under 5)	20% after deductible	$40	30% after deductible	$30 (waived for children under 5)
Specialty care office visit	$125	$85 after deductible	20% after deductible	$80	30% after deductible	$60
Most X-rays	$80 after deductible	50% after deductible	20% after deductible	$80	30% after deductible	$70
Most lab tests	$55 after deductible	50% after deductible	20% after deductible	$60	30% after deductible	$40
MRI, CT, PET	$500 after deductible	50% after deductible	20% after deductible	$300	30% after deductible	35% after deductible
Outpatient surgery	40% after deductible	50% after deductible	20% after deductible	20% after deductible	30% after deductible	35% after deductible
Mental health visit	$60 (individual therapy)	$65 (individual therapy)	20% after deductible	$40 (individual therapy)	30% after deductible	$30 (individual therapy)
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	50% after deductible	20% after deductible	20% after deductible	30% 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	40% after deductible	50% after deductible	20% after deductible	20% after deductible	30% after deductible	35% after deductible
Emergency and urgent care						
Emergency Department visit	40% after deductible	50% after deductible	20% after deductible	$350 after deductible (copay waived if admitted)	30% after deductible	35% after deductible
Urgent care visit	$100	$85 after deductible	20% after deductible	$90	30% after deductible	$60
Prescription drugs (up to a 30-day supply)						
Generic	$25†	$40†	20% after deductible	$15†	$20 after deductible†	$20†
Preferred brand	$75 after $850 pharmacy deductible per member†	50% after deductible	20% after deductible	$50 after $250 pharmacy deductible per member†	$55 after deductible†	$60 after $800 pharmacy deductible per member†
Non-preferred brand	$100 after $850 pharmacy deductible per member†	50% after deductible	20% after deductible	$70 after $250 pharmacy deductible per member†	20% after deductible	35% after $800 pharmacy deductible per member
Specialty	$150 after $850 pharmacy deductible per member per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription	20% after deductible up to $150 maximum per 30-day prescription	$150 after $250 pharmacy deductible per member per 30-day prescription	30% after deductible up to $150 maximum per 30-day prescription	35% after $800 pharmacy deductible per member up to $150 maximum per 30-day prescription
Whole health						
Healthy Services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit kp.org/selfcare for more details.					

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 **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. The out-of-pocket maximum includes the annual deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

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

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

	KP DC Gold 1600/25%/HSA/ Vision	KP DC Gold 1000/20/Vision	KP DC Standard Gold 500/25/Vision	KP DC Gold 0/20/Vision	KP DC Standard Platinum 0/20/Vision	KP DC Catastrophic‡ 8550/0/Vision
Plan type	**HSA-qualified**	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features						
Annual medical deductible (individual/family)	$1,600 (subscriber-only plan) $3,200/$3,200 (family plan)††	$1,000/$2,000	$500/$1,000	None/None	None/None	$8,550/$17,100
Annual out-of-pocket maximum (individual/family)	$5,000/$10,000	$6,950/$13,900	$4,950/$9,900	$6,950/$13,900	$2,000/$4,000	$8,550/$17,100
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	$25 after deductible (copay waived for children under 5)	$20 (waived for children under 5)	$25	$20 (waived for children under 5)	$20	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	$50 after deductible	$40	$50	$40	$40	No charge after deductible
Most X-rays	$65 after deductible	$70	$50	$65	$40	No charge after deductible
Most lab tests	$30 after deductible	$40	$30	$30	$20	No charge after deductible
MRI, CT, PET	25% after deductible	$500	$250	$500	$150	No charge after deductible
Outpatient surgery	25% after deductible	35% after deductible	$600	35%	$250	No charge after deductible
Mental health visit	$25 after deductible (individual therapy)	$20 (individual therapy)	$25 (individual therapy)	$20 (individual therapy)	$20 (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	25% after deductible	35% after deductible	$600 per day up to 5 days after deductible*	35%	$250 per day up to 5 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	25% after deductible	35% after deductible	$600 per day up to 5 days after deductible*	35%	$250 per day up to 5 days*	No charge after deductible
Emergency and urgent care						
Emergency Department visit	$500 after deductible (copay waived if admitted)	$500 (waived if admitted)	$300 (waived if admitted)	$500 (waived if admitted)	$150 (waived if admitted)	No charge after deductible
Urgent care visit	$50 after deductible	$40	$60	$40	$40	No charge after deductible
Prescription drugs (up to a 30-day supply)						
Generic	$15 after deductible†	$10†	$15†	$15†	$5†	No charge after deductible
Preferred brand	$50 after deductible†	$55†	$50†	$55†	$15†	No charge after deductible
Non-preferred brand	25% after deductible	35% after $200 pharmacy deductible per member	$70†	35% after $150 pharmacy deductible per member	$25†	No charge after deductible
Specialty	25% after deductible up to $150 maximum per 30-day prescription	35% after $200 pharmacy deductible per member up to $150 maximum per 30-day prescription	$150 per 30-day prescription	35% after $150 pharmacy deductible per member up to $150 maximum per 30-day prescription	$100 per 30-day prescription	No charge after deductible
Whole health						
Healthy Services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.					

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 **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. The out-of-pocket maximum includes the annual deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 5 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 benefit exchange in DC demonstrating hardship or lack of affordable coverage, may purchase a KP DC Catastrophic 8550/0/Vision plan.

**The KP DC Catastrophic 8550/0/Vision plan includes 3 office visits at no charge before you reach your deductible. Office visits include primary or outpatient mental health office visit.

††For the KP DC Gold 1600/25%/HSA/Vision plan, in a subscriber-only plan, the individual deductible is $1,600. In a family version of the KP DC Gold 1600/25%/HSA/Vision plan, there is no individual member deductible of $1,600. Instead, there is only a family deductible of $3,200, that can be met by one or more family members. Once the combined contribution of all covered family members has reached the applicable deductible of $3,200, the deductible will be satisfied for all family members and they begin paying only the applicable copayments and coinsurance amounts for the remainder of the plan year.

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through dchealthlink.com.

	KP DC Silver 2000/20%/CSR/ Vision (3200)	KP DC Silver 600/10%/CSR/ Vision (3200)	KP DC Silver 100/5%/Vision (3200)	KP DC Silver 2200/30/CSR/ Vision (2500)	KP DC Silver 0/10/CSR/ Vision (2500)
Plan type	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Copayment**
Features					
Annual medical deductible (individual/family)	$2,000/$4,000	$600/$1,200	$100/$200	$2,200/$4,400	None/None
Annual out-of-pocket maximum (individual/family)	$6,650/$13,300	$2,700/$5,400	$2,300/$4,600	$6,550/$13,100	$2,700/$5,400
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% after deductible	10% after deductible	5% after deductible	$30 (waived for children under 5)	$10 (waived for children under 5)
Specialty care office visit	20% after deductible	10% after deductible	5% after deductible	$55	$40
Most X-rays	20% after deductible	10% after deductible	5% after deductible	$70	$40
Most lab tests	20% after deductible	10% after deductible	5% after deductible	$40	$40
MRI, CT, PET	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Outpatient surgery	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Mental health visit	20% after deductible	10% after deductible	5% after deductible	$30 (individual therapy)	$10 (individual therapy)
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Emergency and urgent care					
Emergency Department visit	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Urgent care visit	20% after deductible	10% after deductible	5% after deductible	$55	$40
Prescription drugs (up to a 30-day supply)					
Generic	$20 after deductible†	$15 after deductible†	$10 after deductible†	$20†	$10†
Preferred brand	$55 after deductible†	$50 after deductible†	$15 after deductible†	$60 after $800 pharmacy deductible per member†	$60†
Non-preferred brand	20% after deductible	10% after deductible	5% after deductible	35% after $800 pharmacy deductible per member	30% after $50 pharmacy deductible per member
Specialty	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	35% after $800 pharmacy deductible per member up to $150 maximum per 30-day prescription	30% after $50 pharmacy deductible per member up to $150 maximum per 30-day prescription
Whole health					
Healthy Services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit kp.org/selfcare for more details.				

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 **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. The out-of-pocket maximum includes the annual deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

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

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through dchealthlink.com.

	KP DC Standard Silver 3500/40/CSR/ Vision (4000)	KP DC Standard Silver 100/25/CSR Vision (4000)	KP DC Standard Silver 0/5/CSR/ Vision (4000)	KP DC Silver 0/5/CSR/ Vision (2500)
Plan type	**Deductible**	**Deductible**	**Copayment**	**Copayment**
Features				
Annual medical deductible (individual/family)	$3,500/$7,000	$100/$200	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,600/$13,200	$2,700/$5,400	$2,250/$4,500	$1,800/$3,600
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	$40	$25	$5	$5 (waived for children under 5)
Specialty care office visit	$75	$40	$10	$15
Most X-rays	$80	$50	$5	$20
Most lab tests	$60	$35	$5	$5
MRI, CT, PET	$300	$150	$50	10%
Outpatient surgery	20% after deductible	20% after deductible	10%	10%
Mental health visit	$40 (individual therapy)	$25 (individual therapy)	$5	$5
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	20% after deductible	10%	10%
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	20% after deductible	10%	10%
Emergency and urgent care				
Emergency Department visit	$350 after deductible (copay waived if admitted)	$250 after deductible (copay waived if admitted)	$250 (copay waived if admitted)	10%
Urgent care visit	$75	$40	$10	$15
Prescription drugs (up to a 30-day supply)				
Generic	$15†	$15†	$5†	$5†
Preferred brand	$50 after $250 pharmacy deductible per member†	$50†	$10†	$10†
Non-preferred brand	$70 after $250 pharmacy deductible per member†	$70†	$35†	10%
Specialty	$150 after $250 pharmacy deductible per member per 30-day prescription	$150 per 30-day prescription	$100 per 30-day prescription	20% up to $150 maximum per 30-day prescription
Whole health				
Healthy Services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit kp.org/selfcare for more details.			

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 **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. The out-of-pocket maximum includes the annual deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

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

Find your rate

Use the monthly rates chart 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.

How is your rate determined?

Your rate is based on:

- The plan you choose
- Where you live, based on your county and ZIP code
- Your age on your plan 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.

Family members include:

- 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 need to pay for the 3 oldest. The other children under 21 will be covered at no charge.

The rates in the monthly rates chart apply to these ZIP codes. 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 Washington, D.C.

20001–13	20232–33	20330	20463	56901–02
20015–20	20235	20340	20468–70	56904
20022	20237–42	20350	20472	56908
20024	20244–45	20355	20500–11	56915
20026–27	20250–52	20370	20515	56920
20029–30	20254	20372–76	20520–31	56933
20032–33	20260–62	20380	20533–44	56935
20035–45	20265–66	20388–95	20546–49	56944–45
20047	20268	20398	20551–55	56950
20049–50	20270	20401–29	20557	56965
20052–53	20277	20431	20559–60	56966
20055–71	20289	20433–37	20565–66	56967
20073–78	20299	20439–42	20570–73	56968
20080–82	20301	20444	20575–81	56969
20090–91	20303	20447	20585–86	56970
20201–04	20306	20451	20590–91	56972
20206–08	20310	20453	20593–94	56998
20210–24	20314	20456	20597	56999
20226–30	20317–19	20460	20599	88888

2021 Monthly rates

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

Age on 2021 effective date	KP DC Standard Bronze 7500/60/ Vision	KP DC Bronze 6500/65/Vision	KP DC Standard Bronze 6350/20%/HSA/ Vision	KP DC Standard Silver 4000/40/ Vision	KP DC Silver 3200/30%/HSA/ Vision	KP DC Silver 2500/30/Vision	KP DC Gold 1600/25%/HSA/ Vision	KP DC Gold 1000/20/Vision	KP DC Standard Gold 500/25/ Vision
0-14	$250.72	$234.43	$236.37	$279.15	$257.77	$283.59	$289.33	$301.90	$316.09
15	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
16	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
17	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
18	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
19	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
20	250.72	234.43	236.37	279.15	257.77	283.59	289.33	301.90	316.09
21	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
22	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
23	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
24	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
25	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
26	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
27	278.71	260.60	262.75	310.31	286.54	315.25	321.63	335.60	351.37
28	285.23	266.69	268.89	317.57	293.24	322.62	329.15	343.45	359.59
29	291.36	272.43	274.68	324.40	299.55	329.56	336.23	350.83	367.32
30	298.65	279.24	281.54	332.51	307.04	337.80	344.64	359.60	376.50
31	306.31	286.41	288.77	341.04	314.92	346.47	353.48	368.84	386.17
32	313.21	292.86	295.28	348.73	322.01	354.28	361.45	377.15	394.87
33	320.50	299.67	302.14	356.84	329.50	362.52	369.85	385.92	404.05
34	328.16	306.84	309.37	365.37	337.38	371.19	378.70	395.15	413.72
35	335.83	314.01	316.60	373.91	345.27	379.86	387.55	404.38	423.38
36	343.50	321.18	323.83	382.45	353.15	388.53	396.40	413.61	433.05
37	351.17	328.35	331.06	390.98	361.03	397.21	405.24	422.85	442.72
38	355.38	332.29	335.03	395.68	365.37	401.98	410.11	427.92	448.03
39	359.60	336.23	339.01	400.37	369.70	406.75	414.98	433.00	453.35
40	373.79	349.50	352.38	416.17	384.29	422.79	431.35	450.08	471.23
41	388.35	363.12	366.12	432.39	399.26	439.27	448.16	467.62	489.60
42	403.69	377.46	380.57	449.46	415.03	456.61	465.85	486.09	508.93
43	419.41	392.15	395.39	466.96	431.19	474.39	483.99	505.02	528.75
44	435.89	407.57	410.93	485.31	448.14	493.04	503.02	524.87	549.53
45	452.76	423.34	426.83	504.09	465.48	512.12	522.48	545.18	570.80
46	470.40	439.83	443.46	523.73	483.61	532.07	542.83	566.41	593.03
47	488.80	457.04	460.81	544.22	502.53	552.88	564.07	588.57	616.23
48	507.97	474.96	478.88	565.56	522.24	574.56	586.19	611.65	640.39
49	527.90	493.60	497.67	587.75	542.73	597.11	609.19	635.66	665.52
50	548.60	512.96	517.19	610.80	564.01	620.53	633.08	660.58	691.62
51	570.07	533.03	537.43	634.71	586.09	644.81	657.86	686.43	718.69
52	592.31	553.82	558.39	659.46	608.95	669.96	683.52	713.21	746.72
53	615.31	575.33	580.07	685.07	632.60	695.98	710.06	740.91	775.72
54	639.46	597.91	602.84	711.96	657.43	723.30	737.94	769.99	806.17
55	664.38	621.21	626.34	739.71	683.05	751.48	766.69	799.99	837.58
56	690.45	645.59	650.91	768.73	709.85	780.97	796.78	831.38	870.45
57	717.29	670.68	676.21	798.61	737.44	811.32	827.74	863.70	904.28
58	745.27	696.85	702.59	829.77	766.21	842.98	860.04	897.40	939.56
59	774.41	724.09	730.06	862.21	796.16	875.94	893.66	932.48	976.30
60	804.69	752.41	758.61	895.93	827.30	910.19	928.61	968.95	1,014.48
61	836.13	781.80	788.25	930.93	859.62	945.75	964.89	1,006.80	1,054.11
62	836.13	781.80	788.25	930.93	859.62	945.75	964.89	1,006.80	1,054.11
63	836.13	781.80	788.25	930.93	859.62	945.75	964.89	1,006.80	1,054.11
64+	836.13	781.80	788.25	930.93	859.62	945.75	964.89	1,006.80	1,054.11

Rates are effective January 1, 2021, through December 31, 2021.

2021 Monthly rates

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

Age on 2021 effective date	KP DC Gold 0/20/Vision	KP DC Standard Platinum 0/20/ Vision	KP DC Catastrophic 8550/0/Vision	KP DC Standard Silver 3500/40/CSR/Vision (4000) KP DC Standard Silver 100/25/CSR/Vision (4000) KP DC Standard Silver 0/5/CSR/Vision (4000)	KP DC Silver 2000/20%/CSR/Vision (3200) KP DC Silver 600/10%/CSR/Vision (3200) KP DC Silver 100/5%/CSR/Vision (3200)	KP DC Silver 2200/30/CSR/Vision (2500) KP DC Silver 0/10/CSR/Vision (2500) KP DC Silver 0/5/CSR/Vision (2500)
0-14	$317.37	$357.99	$178.25	$279.15	$257.77	$283.59
15	317.37	357.99	178.25	279.15	257.77	283.59
16	317.37	357.99	178.25	279.15	257.77	283.59
17	317.37	357.99	178.25	279.15	257.77	283.59
18	317.37	357.99	178.25	279.15	257.77	283.59
19	317.37	357.99	178.25	279.15	257.77	283.59
20	317.37	357.99	178.25	279.15	257.77	283.59
21	352.79	397.95	198.15	310.31	286.54	315.25
22	352.79	397.95	198.15	310.31	286.54	315.25
23	352.79	397.95	198.15	310.31	286.54	315.25
24	352.79	397.95	198.15	310.31	286.54	315.25
25	352.79	397.95	198.15	310.31	286.54	315.25
26	352.79	397.95	198.15	310.31	286.54	315.25
27	352.79	397.95	198.15	310.31	286.54	315.25
28	361.04	407.26	202.78	317.57	293.24	322.62
29	368.80	416.01	207.14	324.40	299.55	329.56
30	378.02	426.41	212.32	332.51	307.04	337.80
31	387.73	437.36	217.77	341.04	314.92	346.47
32	396.46	447.21	222.68	348.73	322.01	354.28
33	405.68	457.62	227.86	356.84	329.50	362.52
34	415.39	468.56	233.31	365.37	337.38	371.19
35	425.09	479.51	238.76	373.91	345.27	379.86
36	434.80	490.46	244.21	382.45	353.15	388.53
37	444.51	501.41	249.66	390.98	361.03	397.21
38	449.84	507.43	252.66	395.68	365.37	401.98
39	455.18	513.45	255.66	400.37	369.70	406.75
40	473.14	533.70	265.74	416.17	384.29	422.79
41	491.58	554.50	276.10	432.39	399.26	439.27
42	510.99	576.40	287.00	449.46	415.03	456.61
43	530.88	598.84	298.18	466.96	431.19	474.39
44	551.75	622.38	309.90	485.31	448.14	493.04
45	573.10	646.46	321.89	504.09	465.48	512.12
46	595.42	671.64	334.43	523.73	483.61	532.07
47	618.72	697.92	347.51	544.22	502.53	552.88
48	642.98	725.29	361.14	565.56	522.24	574.56
49	668.21	753.75	375.31	587.75	542.73	597.11
50	694.42	783.31	390.03	610.80	564.01	620.53
51	721.59	813.96	405.29	634.71	586.09	644.81
52	749.74	845.71	421.10	659.46	608.95	669.96
53	778.86	878.56	437.46	685.07	632.60	695.98
54	809.43	913.04	454.63	711.96	657.43	723.30
55	840.97	948.62	472.34	739.71	683.05	751.48
56	873.97	985.84	490.88	768.73	709.85	780.97
57	907.94	1,024.16	509.96	798.61	737.44	811.32
58	943.36	1,064.12	529.85	829.77	766.21	842.98
59	980.24	1,105.72	550.57	862.21	796.16	875.94
60	1,018.58	1,148.96	572.10	895.93	827.30	910.19
61	1,058.37	1,193.85	594.45	930.93	859.62	945.75
62	1,058.37	1,193.85	594.45	930.93	859.62	945.75
63	1,058.37	1,193.85	594.45	930.93	859.62	945.75
64+	1,058.37	1,193.85	594.45	930.93	859.62	945.75

Rates are effective January 1, 2021, through December 31, 2021.

Learn about vision and dental coverage

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

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, and find information about other vision benefits, visit **kp2020.org**.

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.

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 and a $10 copay for most preventive care procedures. To enroll, select the option on your application to enhance your dental coverage with the dental HMO rider.

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 **1-855-733-7524.**

Benefits, Exclusions, and Limitations

Medical Exclusions

This provision provides information on what services we will not pay for regardless of whether or not the service is medically necessary.

When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service.

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

The following services are excluded from coverage:

1. **Certain Alternative Medical Services,** except when used for anesthesia, acupuncture services and any other services of an Acupuncturist, Naturopath, and Massage Therapist.
2. **Certain Exams and Services:** Physical examinations and other services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, licensing, or disability determinations; or
   c. On court-order or required for parole or probation.
3. **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.
4. **Custodial Care,** meaning 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.
5. **Disposable Supplies** for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages.
6. **Durable Medical Equipment,** except for equipment that we would specifically cover.
7. **Employer or Government Responsibility:** Financial responsibility for services that an employer or government agency is required by law to provide.
8. **Experimental or Investigational Services:** 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:
   a. It cannot be legally marketed in the United States without the approval of the federal Food and Drug Administration (FDA) and such approval has not been granted; or
   b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
   c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
   d. It is the subject of a written protocol used by the treating facility for research, 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:

   a. your medical records;
   b. the written protocols or other documents pursuant to which the service has been or will be provided;

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

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

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

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

We will consult our Medical Group and then uses the criteria described above to decide if a particular service is experimental or investigational.

9. **External Prosthetic and Orthotic Devices:** Services and supplies for external prosthetic and orthotic devices.
10. **Infertility Services:**
    a. Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures.
    b. Any services or supplies provided to a person not covered under any health plans in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
    c. Drugs used to treat infertility.
11. **Prohibited Referrals:** Payment of any claim, bill, or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law.
12. **Routine Foot Care Services.**
13. **Services for Members in the Custody of Law Enforcement Officers:** Non-plan provider services provided or arranged by criminal justice institutions for members in the custody of law enforcement officers, unless the services are covered as emergency services.
14. **Surrogacy Arrangements:** A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child. You must pay us charges for services you receive related to conception, pregnancy or delivery in connection with a surrogacy arrangement (Surrogacy Health Services). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within thirty (30) days of entering into a surrogacy arrangement, you must provide us written notice of the arrangement, including a copy of any agreement, the names and addresses of the other parties to the arrangement.

You must complete and send us all consents, releases, authorizations, lien forms, assignments and other documents that are reasonably necessary for us to determine the existence of any rights we may have under "Surrogacy Arrangements" and to satisfy those rights. You must not take any action that prejudices our rights.

If your estate, parent, guardian, spouse, domestic partner or legal partner, trustee, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, spouse, domestic partner or legal partner, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

15. **Travel and Lodging Expenses,** except in some situations when a plan physician refers you to a provider outside of our service area, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.
16. **Worker's Compensation or Employer 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 a "Financial Benefit"), is provided under any worker's compensation or employer 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:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
    b. 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 employers' liability law.

Medical Limitations

We will make our best efforts to provide or arrange for your health care services in the event of unusual circumstances for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a plan hospital or plan medical center; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide services, we, 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. If you still refuse to accept the recommended services, we and plan providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

Pharmacy Exclusions

We do not cover:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a plan provider and are listed in our Preferred Drug List;
2. Drugs for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits;
3. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List;
4. Drugs obtained from a non-plan pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered services are rendered or associated with a covered authorized referral outside the service area;
5. Take home drugs received from a hospital, skilled nursing facility, or other similar facility;
6. Drugs that are not listed in our Preferred Drug List;
7. Drugs that are considered to be experimental or investigational;
8. Drugs for which the member is not legally obligated to pay, or for which no charge is made;
9. Blood or blood products;
10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss;
11. Medical foods;
12. Drugs for the palliation and management of

terminal illness if they are provided by a licensed hospice agency to a member participating in our hospice care program;

13. Replacement prescriptions necessitated by theft or loss;
14. Prescribed drugs and accessories that are necessary for services we do not cover;
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from our standard packaging for prescription drugs;
16. Alternative formulations or delivery methods that are:
    a. Different from our standard formulation or delivery method for prescription drugs; and
    b. Deemed not medically necessary.
17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies;
18. Drugs and devices that are provided during a covered stay in a hospital or skilled nursing facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug;
19. Bandages or dressings;
20. Diabetic equipment and supplies;
21. Growth hormone therapy for treatment of adults age 18 or older, except when prescribed by a plan physician, pursuant to clinical guidelines for adults;
22. Immunizations and vaccinations solely for the purpose of travel;
23. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee;
24. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction;
26. Drugs for the treatment of infertility.

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Preferred Drug List. If you would like information about whether a particular drug is included in our Preferred Drug List, please visit us online at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_exchange_formulary.pdf

You may also contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at **1-800-777-7902** or **711** (TTY).

Pharmacy Limitations

For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a plan pharmacy or a participating network pharmacy, unless the criteria for coverage of non-preferred brand drugs has been met.

In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with our emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable cost share per prescription will apply. However, a member may file a claim for the difference between the cost share for a full prescription and the pro-rata cost share for the actual amount received.

Except for maintenance medications, members are limited to a thirty (30)-day supply for drugs other than contraceptive drugs and will be charged the applicable cost share based on:

a. The prescribed dosage;

b. Standard manufacturers package size; and

c. Specified dispensing limits.

For maintenance medications, members may obtain up to a ninety (90)-day supply in a single prescription, when authorized by the prescribing plan provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

a. The prescribed dosage;

b. Standard manufacturers package size; and

c. Specified dispensing limits.

Dental Exclusions

The following exclusions apply to covered dental services for children under age nineteen (19) years:

1. Services which are covered under worker's compensation or employer's liability laws;
2. Services which are not necessary for the patient's dental health as determined by us;
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by us;
4. Oral surgery requiring the setting of fractures or dislocations;
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of us, such services should not be performed in a dental office;
6. Dispensing of drugs;
7. Hospitalization for any dental procedure;
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation;
9. Replacement due to loss or theft of prosthetic appliance;
10. Procedures not listed as covered benefits;
11. Services obtained by a non-participating dental provider that was not preauthorized by us, with the exception of out-of-area emergencies dental services;
12. Services related to the treatment of Temporomandibular Disorder (TMD) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services;
13. Services performed by a participating specialist without a referral from a participating general dentist, with the exception of orthodontics;
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by us. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review;
15. Non-medically necessary orthodontia and Phase I Treatment for medically necessary orthodontia are not covered benefits. A discount is provided to members through our agreements with our participating orthodontists. These provider agreements create no liability for payment by us and payments by the member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit.

Dental Limitations

The following limitations apply to covered dental services for children under age nineteen (19) years:

1. One (1) evaluation is covered per six (6) months, per patient. Comprehensive oral evaluations are limited to once per twelve (12) months;
2. One (1) teeth cleaning is covered per six (6) months, per patient;
3. One (1) fluoride application is covered per (6) six months, per patient;
4. One (1) set of bitewing x-rays is covered per six (6) months, per patient starting at age two (2) years;
5. One (1) set of full mouth x-rays or panoramic film is covered every five (5) years, per patient, starting at age six (6) years. Panoramic x-rays are limited to ages 6-18 years. No more than one (1) set of x-rays are covered per visit;
6. One (1) sealant per tooth is covered per thirty-six (36) months, per patient up to age eighteen (18) years (limited to occlusal surfaces of posterior permanent teeth without restorations or decay);
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime;
8. One (1) space maintainer is covered per twenty-four (24) months per patient, per arch;
9. One (1) distal shoe space maintainer, fixed, unilateral per lifetime;
10. Replacement of a filling is covered if it is more than three (3) years from the date of original placement;
11. Replacement of a primary stainless steel crown (under age fifteen (15) years), crown, denture, or other prosthodontic appliance is covered if it is more than five (5) years from the date of original placement;

12. Crown and bridge copayments apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%;
13. Relining and rebasing of dentures is covered once per twenty-four (24) months, per patient;
14. Root canal treatment is covered once per tooth per lifetime;
15. Periodontal scaling and root planing, limited to one (1) per twenty-four (24) months, per patient, per quadrant;
16. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered cleaning, limited to once per two (2) years;
17. Osseous surgery, gingival flap procedure, and gingivectomy or gingivoplasy are limited to one (1) per thirty-six (36) months;
18. Full mouth debridement is covered once per lifetime, per patient;
19. One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years;
20. Localized delivery of antimicrobial agents is limited to one (1) benefit per tooth for three (3) teeth per quadrant; or a total of twelve (12) teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater;
21. Periodontal surgery of any type, including any associated material, is covered once every twenty-four (24) months, per quadrant or surgical site;
22. Periodontal maintenance is covered twice per calendar year in addition to adult prophylaxis, within twenty-four (24) months after definitive periodontal therapy;
23. Coronectomy, intentional partial tooth removal, one (1) per lifetime;
24. Denture rebase and denture reline is limited to one (1) in a thirty-six (36) month period, six (6) months after initial placement;
25. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of sixty (60) minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation;
26. Occlusal guards are covered by report for patients thirteen (13) years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than Temporomandibular Dysfunction (TMD). Occlusal guards are limited to one (1) per twelve (12) consecutive month period;
27. Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions;
28. Fixed partial dentures, buildups, and posts and cores for members under sixteen (16) years of age are only covered if deemed necessary by us;
29. Onlays, crowns, and posts and cores for members twelve (12) years of age or younger are only covered if deemed necessary by us. Cast posts and cores are processed as an alternate benefit of a prefabricated post and core. Posts are eligible only when provided as part of a crown buildup or implant and are considered integral to the buildup or implant;
30. Orthodontics is only covered if medically necessary as determined by us. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility;
31. Synchronous teledentistry or asynchronous teledentistry are limited to two (2) per calendar year.

Women's Health Care Services

This page summarizes the coverage and cost-sharing information for women's health care services being provided by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., to Health Plan members in Washington, D.C.

- All Food & Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under Preventive Care at no charge.
- Coverage at no charge for contraceptive drugs, devices, products and services, including those obtained over-the-counter and those prescribed. Members may obtain up to a 12-month supply of prescription contraceptive drugs all at once or over the course of the 12 months at the patient's election.
- Coverage at no charge for the following Preventive Care services and products:
  - a) Breast cancer screening;
  - b) Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening or molecular breast imaging of the breast, if a:
    - Mammogram demonstrates a Class C or Class D breast density classification; or
    - Woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse.
  - c) Breast feeding support, services and supplies;
  - d) Screening for cervical cancer, including HPV testing;
  - e) Screening for gestational diabetes;
  - f) Screening and counseling for HIV;
  - g) Screening and counseling for interpersonal and domestic violence;
  - h) Screening and counseling for sexually-transmitted diseases;
  - i) Screening and counseling for Hepatitis B and C;
  - j) Well-woman preventive visits, including visits to obtain necessary preventive care, preconception care and prenatal care;
  - k) Folic acid supplementation;
  - l) Breast cancer chemoprevention counseling and preventive medications;
  - m) Risk assessment and genetic counseling and testing using the Breast Cancer Risk Assessment tool approved by the National Cancer Institute; and
  - n) Rh incompatibility screening during pregnancy;
  - o) Evidence-based items, services, prescription-drug items that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force as of September 19, 2017; and
  - p) Any additional health services, products, including contraceptive drugs, devices, products identified by rules issued pursuant to DC Code §31-3834.02 subsection (c).

"No charge" denotes that the services and products above will be provided to the member at no cost even if the plan deductible is not yet met. This results in no financial responsibility for the member. Out-of-network performed services may be subject to cost-sharing.

Exemptible Benefit Notice: An employer organized and operating as a nonprofit entity and referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, approved October 22, 1986 (100 Stat. 2740; 26 U.S.C. § 6033(a)(3)(A)(i) or (iii)), may be exempt from any requirement to cover contraceptive drugs, devices, products, and services under §§ 31-3834.01, 31-3834.02, and 31-3834.03.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት 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**).

Ɓăsɔ́ɔ̀ 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. Ɖá **1-800-777-7902** (TTY: **711**)

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

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

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

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

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

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

Helpful online resources

Have questions about getting started with Kaiser Permanente? Want to learn more about our services? Use this information to explore the resources available to members, or to get answers to any questions you have.

Discover Kaiser Permanente ..... kp.org/thrive

Enrollment resources

Apply online ..... buykp.org/apply

Get started if you're a new member ..... kp.org/newmember

Enroll during a special enrollment period ..... kp.org/specialenrollment

Member resources

Manage your care ..... kp.org

Find a location near you ..... kp.org/facilities

Choose your doctor ..... kp.org/searchdoctors

Create your online account ..... kp.org/registernow

Get an idea of what your care will cost ..... kp.org/treatmentestimates

Get an estimate of what you'll pay for your care ..... kp.org/costestimates

Get a copy of your *Evidence of Coverage* ..... kp.org/plandocuments

Additional resources

Find resources for healthier living ..... kp.org/healthyliving

Get in touch with us by phone

Get general information about Kaiser Permanente 1-800-494-5314

The right choice for a healthier you

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

Want to learn more?

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

Stay connected to good health

facebook.com/kpthrive

youtube.com/kaiserpermanenteorg

@kpthrive, @aboutkp, @kptotalhealth, @kpmidatlantic

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
2101 East Jefferson St.
Rockville, MD 20852

buykp.org

KAISER PERMANENTE®

533337762 District of Columbia 2021