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.

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 MD Gold Value 0/20/Vision (no deductible)	$20 (waived for children under age 5)	$65	$10†
KP MD Silver Value 2500/35/Vision/Off ($2,500 deductible)	$35 (waived for children under age 5)	$70	$20†
KP MD Bronze 6900/0%/HSA/Vision ($6,900 deductible)	No charge after deductible	No charge after deductible	No charge 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 December 15, 2020.
- 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, 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 **marylandhealthconnection.gov** 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 E KP MD Silver Value 2500/35/ Vision/Off KP MD Silver Value 2500/35/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	$35 (waived for children under 5)
Specialty care office visit	$55
Most X-rays	$70
Most lab tests	$50
MRI, CT, PET	35% after deductible
Outpatient surgery	35% after deductible
Mental health visit	$35 (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	$55
Prescription drugs (up to a 30-day supply)	
Generic	$20†
Preferred brand	$60†
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.

†Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.
††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

KP Offered through Kaiser Permanente

E 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 $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 $35 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 $55 copay for urgent care visits, whether or not you have met your deductible.

KP Offered through Kaiser Permanente

E Offered through the Marketplace, Maryland Health Connection

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	KP E KP MD Bronze 7500/40%/Vision	KP E KP MD Bronze 6900/0%/HSA/Vision	KP E KP MD Bronze Value 6000/55/Vision	KP E KP MD Silver 6000/40/Vision/Off KP MD Silver 6000/40/Vision	KP E KP MD Silver 3200/20%/HSA/Vision/Off KP MD Silver 3200/20%/HSA/Vision
Plan type	**Deductible**	**HSA-qualified**	**Deductible**	**Deductible**	**HSA-qualified**
Features					
Annual medical deductible (individual/family)	$7,500/$15,000	$6,900/$13,800	$6,000/$12,000	$6,000/$12,000	$3,200/$6,400
Annual out-of-pocket maximum (individual/family)	$8,550/$17,100	$6,900/$13,800	$8,550/$17,100	$8,500/$17,000	$6,650/$13,300
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	40% after deductible	No charge after deductible	First 3 visits $55, then 40% after deductible (copay waived for children under 5)	$40 (waived for children under 5)	20% after deductible
Specialty care office visit	40% after deductible	No charge after deductible	40% after deductible	$60	20% after deductible
Most X-rays	40% after deductible	No charge after deductible	40% after deductible	$70	20% after deductible
Most lab tests	40% after deductible	No charge after deductible	40% after deductible	$50	20% after deductible
MRI, CT, PET	40% after deductible	No charge after deductible	40% after deductible	35% after deductible	20% after deductible
Outpatient surgery	40% after deductible	No charge after deductible	40% after deductible	35% after deductible	20% after deductible
Mental health visit	40% after deductible	No charge after deductible	40% after deductible	$40 (individual therapy)	20% after deductible
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	No charge after deductible	40% after deductible	35% after deductible	20% after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	No charge after deductible	40% after deductible	35% after deductible	20% after deductible
Emergency and urgent care					
Emergency Department visit	40% after deductible	No charge after deductible	40% after deductible	35% after deductible	20% after deductible
Urgent care visit	40% after deductible	No charge after deductible	40% after deductible	$60	20% after deductible
Prescription drugs (up to a 30-day supply)					
Generic	40% after deductible††	No charge after deductible	$25†	$30†	$20 after deductible†,††
Preferred brand	40% after deductible††	No charge after deductible	40% after deductible††	$60†	$55 after deductible†,††
Non-preferred brand	50% after deductible††	No charge after deductible	50% after deductible††	50% after deductible††	20% after deductible††
Specialty	50% after deductible up to $150 maximum per 30-day prescription	No charge after deductible	50% after deductible up to $150 maximum per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription	30% after deductible 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.				

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

††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

KP Offered through Kaiser Permanente

E Offered through the Marketplace, Maryland Health Connection

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	KP E KP MD Silver Value 2500/35/Vision/Off KP MD Silver Value 2500/35/Vision	KP E KP MD Gold 1750/20/Vision	KP E KP MD Gold Value 1000/20/Vision
Plan type	**Deductible**	**Deductible**	**Deductible**
Features			
Annual medical deductible (individual/family)	$2,500/$5,000	$1,750/$3,500	$1,000/$2,000
Annual out-of-pocket maximum (individual/family)	$8,250/$16,500	$6,950/$13,900	$6,950/$13,900
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$35 (waived for children under 5)	$20 (waived for children under 5)	$20 (waived for children under 5)
Specialty care office visit	$55	$40	$40
Most X-rays	$70	$70	$70
Most lab tests	$50	$50	$40
MRI, CT, PET	35% after deductible	35% after deductible	$500
Outpatient surgery	35% after deductible	35% after deductible	35% after deductible
Mental health visit	$35 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)
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
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	35% after deductible	35% after deductible
Emergency and urgent care			
Emergency Department visit	35% after deductible	35% after deductible	$500 (waived if admitted)
Urgent care visit	$55	$40	$40
Prescription drugs (up to a 30-day supply)			
Generic	$20†	$15†	$10†
Preferred brand	$60†	$55 after $250 pharmacy deductible per member††	$55†
Non-preferred brand	35% after $800 pharmacy deductible per member††	50% after $250 pharmacy deductible per member††	35% after $200 pharmacy deductible per member††
Specialty	35% after $800 pharmacy deductible per member up to $150 maximum per 30-day prescription	50% after $250 pharmacy deductible per member up to $150 maximum per 30-day prescription	35% after $150 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.		

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

††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

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	KP E KP MD Gold Value 0/20/Vision	KP E KP MD Platinum 0/15/Vision	KP E KP MD Catastrophic‡ 8550/0/Vision
Plan type	**Copayment**	**Copayment**	**Deductible**
Features			
Annual medical deductible (individual/family)	None/None	None/None	$8,550/$17,100
Annual out-of-pocket maximum (individual/family)	$6,950/$13,900	$4,000/$8,000	$8,550/$17,100
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$20 (waived for children under 5)	$15 (waived for children under 5)	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	$40	$20	No charge after deductible
Most X-rays	$65	$20	No charge after deductible
Most lab tests	$30	$20	No charge after deductible
MRI, CT, PET	$500	$250	No charge after deductible
Outpatient surgery	35%	$350	No charge after deductible
Mental health visit	$20 (individual therapy)	$15 (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%	$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
Delivery and inpatient well-baby care	35%	$350 per day up to 4 days*	No charge after deductible
Emergency and urgent care			
Emergency Department visit	$500 (waived if admitted)	$300 (waived if admitted)	No charge after deductible
Urgent care visit	$40	$20	No charge after deductible
Prescription drugs (up to a 30-day supply)			
Generic	$10†	$5†	No charge after deductible
Preferred brand	$55†	$35†	No charge after deductible
Non-preferred brand	35% after $150 pharmacy deductible per member††	$55†	No charge after deductible
Specialty	35% after $150 pharmacy deductible per member up to $150 maximum per 30-day prescription	$150†	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.		

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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 benefit exchange in Maryland demonstrating hardship or lack of affordable coverage, may purchase a KP MD Catastrophic 8550/0/Vision plan.

**The KP MD Catastrophic 8550/0/Vision plan includes three office visits at no charge before your deductible applies. Office visits include primary or outpatient mental health office visits.

††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

E 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.

	E KP MD Silver 3500/35/CSR/ Vision (6000)	E KP MD Silver 0/15/CSR/ Vision (6000)	E KP MD Silver 0/5/CSR/ Vision (6000)
Plan type	**Deductible**	**Copayment**	**Copayment**
Features			
Annual medical deductible (individual/family)	$3,500/$7,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000	$2,700/$5,400	$2,000/$4,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$35 (waived for children under 5)	$15 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$55	$40	$15
Most X-rays	$55	$40	$15
Most lab tests	$40	$40	$10
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	$35 (individual therapy)	$15 (individual therapy)	$5
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	$55	$40	$15
Prescription drugs (up to a 30-day supply)			
Generic	$25†	$15†	$5†
Preferred brand	$60†	$60†	$15†
Non-preferred brand	35% after deductible††	30%††	10%††
Specialty	35% up to $150 maximum per 30-day prescription	30% up to $150 maximum per 30-day prescription	10% up to $150 maximum per 30-day prescription
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.		

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

††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

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Cost Share Reduction (CSR) Plans

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	E KP MD Silver 2000/20%/CSR/Vision (3200)	E KP MD Silver 600/10%/CSR/Vision (3200)	E KP MD Silver 100/5%/CSR/Vision (3200)
Plan type	**Deductible**	**Deductible**	**Deductible**
Features			
Annual medical deductible (individual/family)	$2,000/$4,000	$600/$1,200	$100/$200
Annual out-of-pocket maximum (individual/family)	$6,650/$13,300	$2,700/$5,400	$2,300/$4,600
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	20% after deductible	10% after deductible	5% after deductible
Specialty care office visit	20% after deductible	10% after deductible	5% after deductible
Most X-rays	20% after deductible	10% after deductible	5% after deductible
Most lab tests	20% after deductible	10% after deductible	5% after deductible
MRI, CT, PET	20% after deductible	10% after deductible	5% after deductible
Outpatient surgery	20% after deductible	10% after deductible	5% after deductible
Mental health visit	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	20% after deductible	10% after deductible	5% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5% after deductible
Emergency and urgent care			
Emergency Department visit	20% after deductible	10% after deductible	5% after deductible
Urgent care visit	20% after deductible	10% after deductible	5% after deductible
Prescription drugs (up to a 30-day supply)			
Generic	$20 after deductible†,††	$15 after deductible†,††	$10 after deductible†,††
Preferred brand	$55 after deductible†,††	$50 after deductible†,††	$15 after deductible†,††
Non-preferred brand	20% after deductible††	10% after deductible††	5% after deductible††
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
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.		

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††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-day supply.

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Cost Share Reduction (CSR) Plans

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	E KP MD Silver 2200/30/CSR/Vision (2500)	E KP MD Silver 0/10/CSR/Vision (2500)	E KP MD Silver 0/5/CSR/Vision (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)	$6,500/$13,000	$2,700/$5,400	$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	$55	$40	$15
Most X-rays	$70	$40	$20
Most lab tests	$45	$40	$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
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	$55	$40	$15
Prescription drugs (up to a 30-day supply)			
Generic	$20†	$10†	$5†
Preferred brand	$60†	$60†	$10†
Non-preferred brand	35% after $800 pharmacy deductible per member††	30% after $50 pharmacy deductible per member††	10%††
Specialty	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	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 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.

††The cost of diabetes, HIV, or AIDS medications will not exceed $150 per 30-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 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	

†Portions of ZIP code not in service area: 21758, 21769, and 21787.

2021 Monthly rates

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

Age on 2021 effective date	KP MD Bronze 7500/40%/Vision	KP MD Bronze 6900/0%/HSA/Vision	KP MD Bronze Value 6000/55/Vision	KP MD Silver 6000/40/Vision/Off	KP MD Silver 3200/20%/HSA/ Vision/Off	KP MD Silver Value 2500/35/Vision/Off
0–14	$150.73	$153.52	$157.64	$179.42	$175.90	$190.07
15	164.13	167.17	171.65	195.37	191.53	206.97
16	169.25	172.38	177.01	201.47	197.51	213.43
17	174.37	177.60	182.36	207.57	203.49	219.89
18	179.89	183.22	188.13	214.14	209.93	226.84
19	185.41	188.84	193.90	220.70	216.36	233.80
20	191.12	194.66	199.88	227.50	223.03	241.01
21	197.03	200.68	206.06	234.54	229.93	248.46
22	197.03	200.68	206.06	234.54	229.93	248.46
23	197.03	200.68	206.06	234.54	229.93	248.46
24	197.03	200.68	206.06	234.54	229.93	248.46
25	197.82	201.48	206.88	235.48	230.85	249.45
26	201.76	205.50	211.01	240.17	235.45	254.42
27	206.49	210.31	215.95	245.80	240.97	260.39
28	214.17	218.14	223.99	254.94	249.93	270.08
29	220.48	224.56	230.58	262.45	257.29	278.03
30	223.63	227.77	233.88	266.20	260.97	282.00
31	228.36	232.59	238.82	271.83	266.49	287.97
32	233.09	237.40	243.77	277.46	272.01	293.93
33	236.04	240.41	246.86	280.98	275.46	297.66
34	239.19	243.63	250.16	284.73	279.14	301.63
35	240.77	245.23	251.81	286.61	280.97	303.62
36	242.35	246.84	253.45	288.48	282.81	305.61
37	243.92	248.44	255.10	290.36	284.65	307.59
38	245.50	250.05	256.75	292.24	286.49	309.58
39	248.65	253.26	260.05	295.99	290.17	313.56
40	251.80	256.47	263.34	299.74	293.85	317.53
41	256.53	261.29	268.29	305.37	299.37	323.49
42	261.06	265.90	273.03	310.77	304.66	329.21
43	267.37	272.32	279.62	318.27	312.02	337.16
44	275.25	280.35	287.87	327.65	321.21	347.10
45	284.51	289.78	297.55	338.68	332.02	358.78
46	295.55	301.02	309.09	351.81	344.90	372.69
47	307.96	313.66	322.07	366.59	359.38	388.34
48	322.14	328.11	336.91	383.47	375.94	406.23
49	336.13	342.36	351.54	400.13	392.26	423.87
50	351.90	358.41	368.02	418.89	410.65	443.75
51	367.46	374.27	384.30	437.42	428.82	463.38
52	384.60	391.73	402.23	457.82	448.82	484.99
53	401.94	409.39	420.36	478.46	469.06	506.86
54	420.66	428.45	439.94	500.74	490.90	530.46
55	439.38	447.52	459.51	523.02	512.74	554.07
56	459.67	468.19	480.74	547.18	536.43	579.66
57	480.16	489.06	502.17	571.57	560.34	605.50
58	502.03	511.33	525.04	597.61	585.86	633.08
59	512.87	522.37	536.37	610.51	598.51	646.74
60	534.74	544.65	559.25	636.54	624.03	674.32
61	553.65	563.91	579.03	659.06	646.10	698.17
62	566.07	576.55	592.01	673.83	660.59	713.83
63	581.63	592.41	608.29	692.36	678.75	733.45
64+	591.09	602.04	618.18	703.62	689.79	745.38

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 marylandhealthconnection.gov.

Age on 2021 effective date	KP MD Gold 1750/20/Vision	KP MD Gold Value 1000/20/Vision	KP MD Gold Value 0/20/Vision	KP MD Platinum 0/15/Vision	KP MD Catastrophic 8550/0/Vision	KP MD Silver 6000/40/Vision
0–14	$198.75	$203.11	$210.80	$237.65	$108.27	$207.25
15	216.41	221.16	229.53	258.78	117.89	225.67
16	223.17	228.06	236.70	266.86	121.57	232.71
17	229.92	234.97	243.86	274.93	125.25	239.76
18	237.20	242.40	251.58	283.63	129.22	247.34
19	244.47	249.84	259.29	292.33	133.18	254.93
20	252.01	257.54	267.28	301.34	137.28	262.78
21	259.80	265.50	275.55	310.66	141.53	270.91
22	259.80	265.50	275.55	310.66	141.53	270.91
23	259.80	265.50	275.55	310.66	141.53	270.91
24	259.80	265.50	275.55	310.66	141.53	270.91
25	260.84	266.56	276.65	311.90	142.10	271.99
26	266.04	271.87	282.16	318.12	144.93	277.41
27	272.27	278.24	288.78	325.57	148.32	283.91
28	282.40	288.60	299.52	337.69	153.84	294.48
29	290.72	297.09	308.34	347.63	158.37	303.15
30	294.87	301.34	312.75	352.60	160.64	307.48
31	301.11	307.71	319.36	360.05	164.03	313.98
32	307.34	314.09	325.98	367.51	167.43	320.49
33	311.24	318.07	330.11	372.17	169.55	324.55
34	315.40	322.32	334.52	377.14	171.82	328.88
35	317.48	324.44	336.72	379.63	172.95	331.05
36	319.55	326.57	338.93	382.11	174.08	333.22
37	321.63	328.69	341.13	384.60	175.21	335.39
38	323.71	330.81	343.34	387.08	176.35	337.55
39	327.87	335.06	347.74	392.05	178.61	341.89
40	332.02	339.31	352.15	397.02	180.88	346.22
41	338.26	345.68	358.77	404.48	184.27	352.72
42	344.24	351.79	365.10	411.62	187.53	358.96
43	352.55	360.28	373.92	421.57	192.06	367.62
44	362.94	370.90	384.94	433.99	197.72	378.46
45	375.15	383.38	397.89	448.59	204.37	391.19
46	389.70	398.25	413.33	465.99	212.30	406.37
47	406.07	414.98	430.68	485.56	221.21	423.43
48	424.77	434.09	450.52	507.93	231.40	442.94
49	443.22	452.94	470.09	529.99	241.45	462.17
50	464.00	474.18	492.13	554.84	252.77	483.85
51	484.53	495.16	513.90	579.38	263.95	505.25
52	507.13	518.26	537.87	606.41	276.27	528.82
53	529.99	541.62	562.12	633.75	288.72	552.66
54	554.67	566.84	588.30	663.26	302.17	578.39
55	579.35	592.07	614.48	692.77	315.61	604.13
56	606.11	619.41	642.86	724.77	330.19	632.03
57	633.13	647.02	671.52	757.08	344.91	660.21
58	661.97	676.49	702.10	791.56	360.62	690.28
59	676.26	691.10	717.26	808.65	368.40	705.18
60	705.10	720.57	747.84	843.13	384.11	735.25
61	730.04	746.06	774.30	872.95	397.70	761.26
62	746.41	762.78	791.66	892.53	406.62	778.32
63	766.93	783.76	813.42	917.07	417.80	799.73
64+	779.40	796.50	826.65	931.98	424.59	812.73

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 marylandhealthconnection.gov.

Age on 2021 effective date	KP MD Silver 3200/20%/HSA/Vision	KP MD Silver Value 2500/35/Vision	KP MD Silver 3500/35/CSR/Vision (6000) KP MD Silver 0/15/CSR/Vision (6000) KP MD Silver 0/5/CSR/Vision (6000)	KP MD Silver 2000/20%/CSR/Vision (3200) KP MD Silver 600/10%/CSR/Vision (3200) KP MD Silver 100/5%/CSR/Vision (3200)	KP MD Silver 2200/30/CSR/Vision (2500) KP MD Silver 0/10/CSR/Vision (2500) KP MD Silver 0/5/CSR/Vision (2500)
0–14	$203.18	$219.56	$207.25	$203.18	$219.56
15	221.24	239.07	225.67	221.24	239.07
16	228.14	246.53	232.71	228.14	246.53
17	235.05	254.00	239.76	235.05	254.00
18	242.48	262.03	247.34	242.48	262.03
19	249.92	270.07	254.93	249.92	270.07
20	257.62	278.39	262.78	257.62	278.39
21	265.59	287.00	270.91	265.59	287.00
22	265.59	287.00	270.91	265.59	287.00
23	265.59	287.00	270.91	265.59	287.00
24	265.59	287.00	270.91	265.59	287.00
25	266.65	288.15	271.99	266.65	288.15
26	271.96	293.89	277.41	271.96	293.89
27	278.34	300.78	283.91	278.34	300.78
28	288.70	311.97	294.48	288.70	311.97
29	297.20	321.15	303.15	297.20	321.15
30	301.44	325.75	307.48	301.44	325.75
31	307.82	332.63	313.98	307.82	332.63
32	314.19	339.52	320.49	314.19	339.52
33	318.18	343.83	324.55	318.18	343.83
34	322.43	348.42	328.88	322.43	348.42
35	324.55	350.71	331.05	324.55	350.71
36	326.68	353.01	333.22	326.68	353.01
37	328.80	355.31	335.39	328.80	355.31
38	330.93	357.60	337.55	330.93	357.60
39	335.17	362.19	341.89	335.17	362.19
40	339.42	366.79	346.22	339.42	366.79
41	345.80	373.67	352.72	345.80	373.67
42	351.91	380.28	358.96	351.91	380.28
43	360.41	389.46	367.62	360.41	389.46
44	371.03	400.94	378.46	371.03	400.94
45	383.51	414.43	391.19	383.51	414.43
46	398.39	430.50	406.37	398.39	430.50
47	415.12	448.58	423.43	415.12	448.58
48	434.24	469.25	442.94	434.24	469.25
49	453.10	489.62	462.17	453.10	489.62
50	474.34	512.58	483.85	474.34	512.58
51	495.33	535.26	505.25	495.33	535.26
52	518.43	560.22	528.82	518.43	560.22
53	541.80	585.48	552.66	541.80	585.48
54	567.03	612.75	578.39	567.03	612.75
55	592.27	640.01	604.13	592.27	640.01
56	619.62	669.57	632.03	619.62	669.57
57	647.24	699.42	660.21	647.24	699.42
58	676.72	731.28	690.28	676.72	731.28
59	691.33	747.06	705.18	691.33	747.06
60	720.81	778.92	735.25	720.81	778.92
61	746.31	806.47	761.26	746.31	806.47
62	763.04	824.55	778.32	763.04	824.55
63	784.02	847.22	799.73	784.02	847.22
64+	796.77	861.00	812.73	796.77	861.00

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 through My Health Manager.

Adult dental benefit

For an additional premium of $12.99 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 **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. 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 pediatric vision benefits, 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, except when part of a clinical trial;
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;
12. Services incurred before the effective date of coverage for a member;
13. Services incurred after a member's termination of coverage;
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 us;

20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers;
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. 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. 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;
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 us;
28. Treatment of sexual dysfunction not related to organic disease;
29. Services that duplicate benefits provided under federal, state or local laws, regulations or programs;
30. Non-human organs and their implantation;
31. Non-replacement fees for blood and blood products;
32. Lifestyle improvements or physical fitness programs;
33. 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;
34. Weekend admission charges, except for emergencies and maternity, unless authorized by us;
35. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements;
36. 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;
37. Services for conditions that state or local laws, regulations, ordinances or similar provisions require to be provided in a public institution;
38 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 one of our plans and is undergoing a covered transplant; and
    b. Services are not payable by another carrier.
39. Physical examinations required for obtaining or continuing employment, insurance or government licensing;
40. Non-medical ancillary services such as vocational rehabilitation, employment counseling or educational therapy;
41. A private hospital room unless medically necessary and authorized by us;
42. Private duty nursing, unless authorized by us;
43. 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.

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

Except as specifically covered under this Outpatient Prescription Drug Benefit, the Health Plan does not cover a drug:

1. That can be obtained without a prescription, except for over-the-counter contraceptive drugs; or
2. 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.

Pharmacy Limitations

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

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three [3] ten [10]-day supplies), you will be charged only one cost share at the initial dispensing for each thirty (30)-day supply.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

1. The prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member;
2. The prescription drug is anticipated to be required for more than three (3) months;
3. The member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs;
4. The prescription drug is not a Schedule II controlled dangerous substance; and
5. The supply and dispensing of the prescription drug meet all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

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

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:

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

Except for prescription drugs to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), if a drug meets the criteria for a Specialty Drug, then the Member's cost for the drug will not exceed $150 for a thirty (30)-day supply, in accordance with §15-847 of the Insurance Article.

For prescribed contraceptives, members may obtain up to a twelve (12)-month supply for a single dispense at a plan pharmacy or through our mail service delivery program.

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. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or development anomalies;
4. Oral surgery requiring the setting of fractures or dislocations;
5. Dispensing of drugs;
6. Hospitalization for the following:
   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 the 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.
7. Procedures not listed as covered benefits;
8. Services obtained outside of the dental office that are not preauthorized, with the exception of out-of-area emergencies;
9. Services performed by a participating specialist without a referral from a participating general dentist, with the exception of Orthodontics. A referral form is required;
10. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article;
11. Non-medically necessary orthodontia is not a covered benefit. Discounts are 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 two (2) times per calendar year, per patient, per provider/location;
2. One (1) teeth cleaning is covered two (2) times per calendar year, per patient;
3. One (1) topical fluoride application is covered two (2) times per calendar year, per patient; four (4) fluoride varnish treatments are covered per calendar year, per patient for children age three (3) years and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2) years;
4. Two (2) bitewing X-rays are covered per calendar year, per patient, per provider/location;
5. One (1) set of full mouth X-rays or panoramic film is covered every three (3) years. Panoramic X-rays are limited to ages six (6) years and above. No more than one (1) set of X-rays is covered per provider/location;
6. One (1) sealant per tooth is covered per lifetime, per patient, 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 per twenty-four (24) months, per quadrant or per arch, per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment);

9. Replacement of a filling is covered if it is more than three (3) years from the date of original placement;
10. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement;
11. Replacement of a prefabricated resin and stainless-steel crown is covered if it is more than three (3) years from the date of original placement, per tooth, per patient;
12. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan;
13. Relining and rebasing of dentures is covered once per twenty-four (24) months, per patient, only after six (6) months of initial placement;
14. Root canal treatment and retreatment of previous root canal are covered once per tooth per lifetime;
15. Periodontal scaling and root planing, osseous surgery and gingivectomy or gingivoplasty are each limited to one 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. Full mouth debridement is covered once per twenty-four (24) months, per patient;
18. 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;
19. 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 (4) quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater;
20. Periodontal surgery of any type, including any associated material, is covered once every twenty-four (24) months, per quadrant or surgical site;
21. Periodontal maintenance after active therapy is covered two (2) times per calendar year;
22. Coronectomy, intentional partial tooth removal, one (1) per lifetime;
23. All dental services that are to be rendered in a hospital setting require coordination and approval from both the dental insurer and the medical insurer before services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes;
24. 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. Non-intravenous conscious sedation is not covered in conjunction with analgesia;
25. 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;
26. Synchronous teledentistry or asynchronous teledentistry are limited to two (2) per calendar year.

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**).

Notes

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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**).

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facebook.com/kpthrive

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