Individuals and Families
Enrollment Guide

Mid-Atlantic States

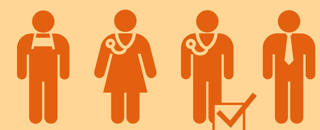
2015

A better choice for good health

KAISER PERMANENTE® thrive

Discover the Kaiser Permanente difference

With health care and health coverage working seamlessly together, Kaiser Permanente is uniquely designed to be your partner in health so you can feel your best — in mind, body, and spirit.



your choice of top doctors

You can choose and change your doctor anytime, for any reason. Our doctors are among the best. They love caring for people and aren't weighed down by a lot of paperwork, so they can focus on you.

personalized care and attention

You're at the center of your care. Your doctors, nurses, and specialists, all connected by your electronic health record, work together to help you manage your health.

everything under one roof

You can do more and drive less because many of our locations include pharmacy, lab, X-ray services, and more.

lots of healthy extras

Stay at your best with healthy resources like wellness classes, many of which are offered at no cost.

online access anytime, anywhere

It's easy to stay involved in your care. Use your computer or mobile device to email your doctor's office, schedule routine appointments, view most lab test results, refill most prescriptions, and more.

healthier tomorrows

Every decision starts with what's best for you. That's why our high-quality care for conditions like cancer, heart disease, and diabetes leads to better outcomes and healthier tomorrows.

kp.org

Note: Many features discussed in this book are available only to members receiving care at Kaiser Permanente medical facilities.

A better choice for good health

Welcome to your *Kaiser Permanente for Individuals and Families Enrollment Guide*. This guide will help you select the right health plan for your needs. Read on to learn why Kaiser Permanente is the best choice.

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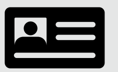

Important deadline

Open enrollment ends **February 15, 2015.** See page 9 for details, and learn about special situations that may allow you to submit your application for health coverage after this date.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is a Qualified Health Plan issuer in the Maryland Health Connection.

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

Understanding health care

Health care coverage makes it easier to get the care you need. This includes all the doctors, nurses, and specialists that provide care and the facilities where you receive care. At Kaiser Permanente, we offer both care and coverage in one package. And now, thanks to the Affordable Care Act (ACA), no one can be denied because of a health problem. This law – also known as health care reform – means more peace of mind for you and your family.

Health care

Almost everyone gets sick or hurt, or needs medical help at some point. To get better, you usually need care – like seeing a doctor, staying in a hospital, taking medication, or all of the above.

On top of that, health care helps keep you healthy. Preventive care – like mammograms and cholesterol level tests – can help you catch health problems early, when they're easier to treat.

Health care includes:

- Doctors' office visits
- Hospital stays
- Emergency Department
- X-rays
- Laboratory tests
- Prescription drugs
- No-charge preventive care, like:
  - Well-baby exams (under 24 months)
  - Well-woman visits
  - Immunizations
  - Health screenings
  - Prenatal exams
  - Vision exams

Health coverage

Health coverage is a lot like the coverage people get to protect their car or home. Without coverage, high medical bills can wipe out savings and even lead to bankruptcy. Health coverage helps protect you financially.

- Each month, you pay a premium – also called a rate – to your health insurance provider.
- When you need care, in most cases your health coverage will help you pay for it.
- If you have a family, you can cover dependents up to the age of 26 in a family plan.
- Do you need help paying for health coverage? Go to page 20 to learn more about federal financial assistance.

Health care reform

It's now the law that most U.S. residents must have health coverage. If you don't have coverage for 3 months in a row or more, you may be charged a tax penalty.

- All our plans meet the standards of the new health care law.
- You can buy one of our plans directly from us or through the Health Insurance Marketplace – government-run websites where you can buy health plans.
- There are 5 types of Kaiser Permanente plans in the Marketplace – Bronze, Silver, Gold, Platinum, and Catastrophic.
- All plans offer the same basics, such as doctor visits, hospital care, prescriptions, and preventive care at no cost.
- The plans differ in how much you pay and when. For example, Bronze has lower monthly premiums but higher out-of-pocket costs. Gold has higher premiums and lower out-of-pocket costs.

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Experience the Kaiser Permanente difference

Get what you need to live well – in one easy-to-use package. Take a look at everything that comes with your plan, and you'll agree that Kaiser Permanente is the best choice for your health.

The experience ...	Without Kaiser Permanente	With Kaiser Permanente*
Choosing your doctor	You have to hope that the doctor you choose takes the insurance you have.	You choose a doctor who's right for you. You can even view all our doctors' profiles online. And you can change your doctor at any time.
Making an appointment	Calling and waiting to schedule an appointment takes forever. You wish you could just hop online to do it.	Schedule or cancel routine appointments with your doctor online or from your mobile device.
During your visit	Your doctor flips through a big file, asking about your medical history.	Your doctor, backed by a secure, innovative electronic health record system, is always up to speed and ready to take care of you.
Getting other services	You go to 3 different locations to take lab tests, get X-rays, or fill prescriptions.	At many locations, your doctor, lab services, X-rays, and pharmacy are all under one roof, so you can save time and do more in one visit.
Visiting a specialist	You show up hoping that your primary care doctor faxed or mailed your records.	When you arrive, your specialist will have your health information right at his or her fingertips, making your care virtually seamless.
Remembering your doctor's instructions kp.org	Take lots of notes during your visit or listen carefully and trust your memory later. Now, was it ice, *then* heat?	You get a printed summary at the end of each visit. You can also view most test results online as soon as they're available.
Asking routine questions without a visit	If you have questions for your doctor, you probably need to call the office and wait for a call back.	Email your doctor's office and get a reply back, normally within 48 hours.

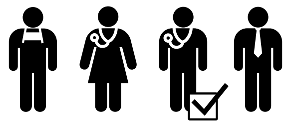
To learn more about Kaiser Permanente, visit **kp.org**.

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

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

The power to choose

Kaiser Permanente makes it easier to stay in charge of your health. It's simple to make smart choices when you have great doctors and convenient facilities.

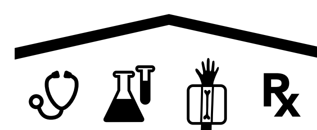


Your choice of top doctors

You have a wide selection of skilled doctors that you can choose from and change anytime, for any reason.

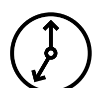
Our doctors:

- Come from many of the top medical schools in the country
- Work hand in hand with your entire care team, who are all connected by your electronic health record
- Don't have excessive paperwork, so they can focus only on delivering the care you need
- Care about their patients and love what they do
- Have individual profiles on **kp.org** that you can browse to learn about their background and credentials



Under-one-roof access

Save time and avoid driving all over town for care. You'll have many locations to choose from, and most of them offer multiple services under one roof. You can see your doctor, get a lab test or an X-ray, and pick up your medications – all without leaving the building. And when you get care with fewer delays, you can get better faster.



Extra conveniences

- Email your doctor's office with routine questions.
- Get same-day, after-hours, and weekend services at most locations.
- Receive personalized care from doctors and staff who speak more than one language.
- Refill most prescriptions online with shipping at no charge.
- Make routine appointments with a call or click.
- View recent office visits and most test results online.
- Call an advice nurse with access to your health information, 24/7.
- Travel freely; you're covered for emergency care worldwide.

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

Hear examples of how Kaiser Permanente has helped different members at **kp.org/kpcarestories**.

Your electronic health record brings it all together

Your doctor's office

Your record gets updated with each visit to a Kaiser Permanente facility, so it's always current.

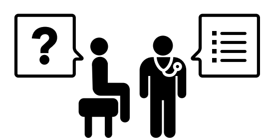
Pharmacy, lab, X-ray

No need for paperwork when you get services at our facilities – your doctor's orders are already there.

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

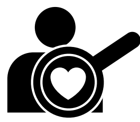
Excellent care

Kaiser Permanente has one of the largest multispecialty medical groups in the country, which includes cardiologists, cardiac surgeons, and others.



Personalized care and attention

A care team that's informed and focused on you can lead to better health. From your doctor and caregivers – who are all connected to your electronic health record and keep up-to-date on how you're doing – to our online programs and Wellness Coaching by Phone service, your care is not one-size-fits-all. It's personalized to your needs and schedule.



Top specialty care for healthier tomorrows

Our doctors, nurses, and other caregivers use an advanced care delivery system that Kaiser Permanente pioneered. It's had a measurable impact on the prevention, detection, and treatment of conditions like cancer, heart disease, stroke, and diabetes. We were also rated in the top 10 percent among cholesterol management programs for patients with cardiovascular conditions.*

Leaders in prevention

We're committed to preventive care and overall wellness. To help keep you from getting sick in the first place, we provide routine appointments, preventive screenings, wellness programs, and much more. As a result, we're #1 in screenings for breast cancer in all our regions, and were rated in the top 10 percent for cervical and colon cancer screenings. Plus, 85 percent of our members who were diagnosed with high blood pressure now have their blood pressure under control, compared to 60 percent nationally.*,†

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

*Ratings based on Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Controlling High Blood Pressure 2013 ratings for commercial plans from the Healthcare Effectiveness Data and Information Set (HEDIS®) published by the National Committee for Quality Assurance. For more information, visit ncqa.org.

†Kaiser Permanente program average is the weighted average of each regional health plan's screening rate and its eligible population.

Learn more about the doctors available in your area at **kp.org/searchdoctors.**

Specialty care

Your specialists are up to speed and ready to take care of you.

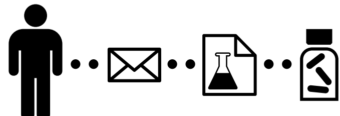
At home or on the go

Get your health information on your computer or mobile device to stay informed and in charge.

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

Your health. Your way.

We're always here when you need us, however you need us. At Kaiser Permanente, you get many services under one roof at most of our locations and can call an advice nurse 24/7. Online or through mobile, you can manage your family's health needs anytime, anywhere.



It's easy to stay connected

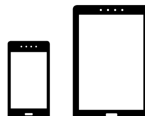
Members registered on kp.org have secure access to My Health Manager, the online tool that helps you manage your family's health care anytime, anywhere.

With My Health Manager, you can:

- Email your doctor's office with routine questions.
- Refill most prescriptions.
- View most lab test results.
- Schedule or cancel routine appointments.

A website full of healthy ideas

Get informed and inspired on our award-winning website, kp.org. Take charge of your health with articles, wellness topics, and health calculators. Our music channels, podcasts, fitness videos, and recipes from world-class chefs can help you find new and interesting ways to live well and thrive.



Good health on the go

Manage your care at home, work, or play with our mobile app, which puts all the convenient features of My Health Manager right in the palm of your hand. You can download the Kaiser Permanente app from the App Store℠ or Google Play®.*

These features are available when you receive care at Kaiser Permanente facilities.
*App Store is a service mark of Apple, Inc., and Google Play is a trademark of Google, Inc.

For a guided tour of My Health Manager, visit **kp.org/myhealthmanagertour.**

Top reasons to join Kaiser Permanente

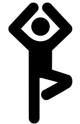
You can choose and change your doctor anytime, for any reason.

Excellent care for conditions like cancer, heart disease, and diabetes leads to healthier tomorrows.

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

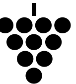
Healthy extras

Good health starts with helpful information and resources. That's why you get lots of healthy extras that can help you stay educated on ways to live healthier in mind, body, and spirit.



Learn something new

Fit wellness into your schedule, no matter how busy you are. With the many health classes offered at our facilities, there's something for everyone. Try classes on yoga, eating well, baby care, ongoing health conditions, and much more. Classes vary by location and some may require a fee.



Wellness Coaching by Phone

Get help making positive changes with your own personal wellness coach. Our experienced and licensed coaches are available to members by phone, at no charge. Your coach will work one-on-one with you to help you set goals to improve your health and get tools, resources, and personalized support to achieve them.

Maximize your health

Our personalized online wellness programs can help you lose weight, stay active, reduce stress, sleep better, stop smoking, and much more. You can also download the Every Body Walk! app for your smartphone or mobile device from the App Store or Google Play. It's a fun, interactive tool to help you create and maintain a daily walking routine.

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

Find tools, tips, and information for living well at **kp.org/livewell.**

Under-one-roof convenience

and care online or by phone means you can manage your health needs anytime, anywhere.

Healthy extras

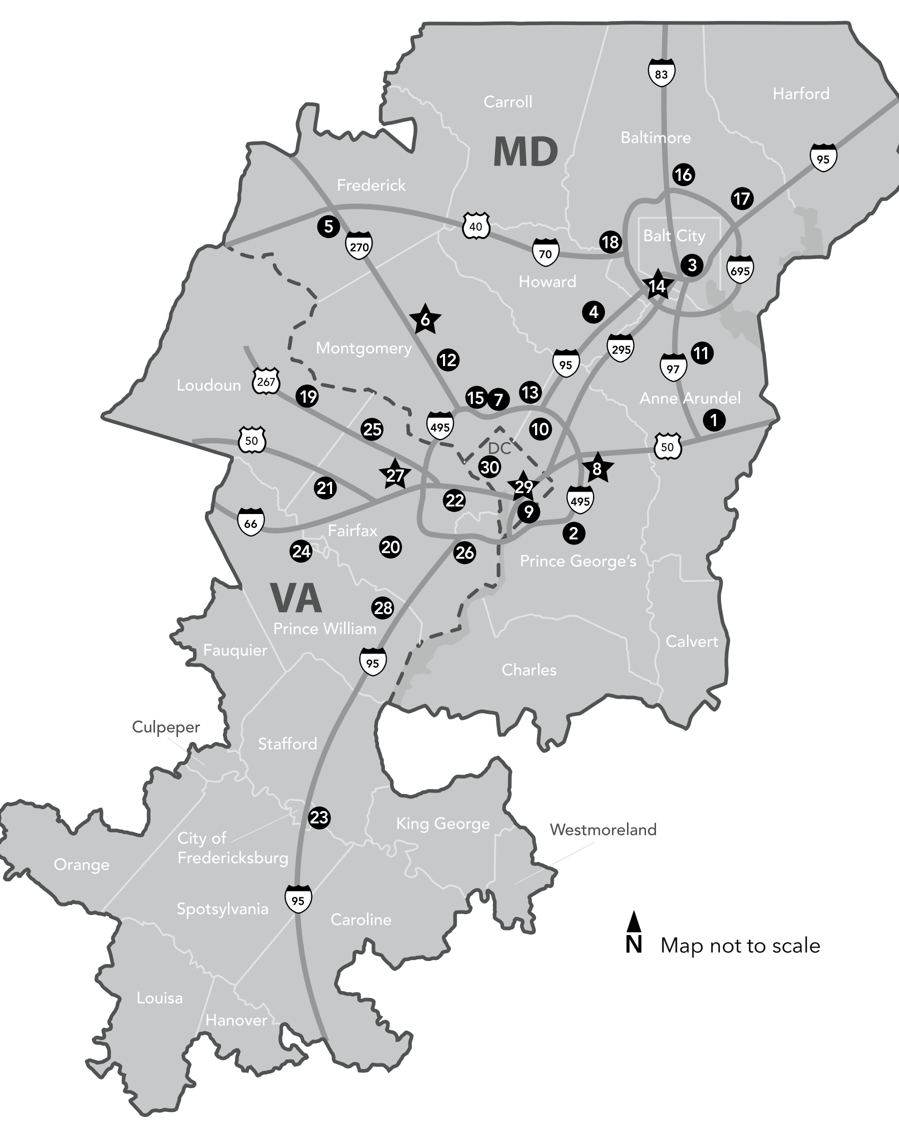
like on-site classes* help you stay well.

*Some classes may require a fee.

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

Find a facility near you

Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or search for a facility by ZIP code or keywords at **buykp.org/facilities** to find the one nearest you.



Kaiser Permanente medical facilities

Maryland

1. Annapolis Medical Center
2. Camp Springs Medical Center
3. City Plaza Medical Center
4. Columbia Gateway Medical Center
5. Kaiser Permanente Frederick Medical Center
6. Gaithersburg Medical Center
7. Kensington Medical Center
8. **EXPANDED** Largo Medical Center
9. Marlow Heights Medical Center
10. Prince George's Medical Center
11. Severna Park Medical Center
12. Shady Grove Medical Center
13. Silver Spring Medical Center
14. **NEW** South Baltimore County Medical Center
15. Summit Behavioral Health Center
16. Towson Medical Center
17. White Marsh Medical Center
18. Woodlawn Medical Center

Virginia

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

Washington, D.C.

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

★ These centers offer **24/7:**

- Urgent care
- Lab
- Pharmacy
- Radiology

†Not available for Medicare Plus enrollees

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

When and how to enroll in your plan

Once you understand why you need health care coverage, the next steps are knowing when and how to enroll and finding out if you qualify for federal financial assistance.

Enrolling during an annual open enrollment period

There's a deadline to apply for health care coverage. You can apply starting November 15, 2014, through February 15, 2015. This is called the open enrollment period. It's when you can enroll in health plans through Maryland Health Connection or directly through Kaiser Permanente.

To enroll during this 2015 open enrollment period, you must make sure we receive your completed Application for Health Coverage – along with your first month's premium – no later than February 15, 2015.

Open enrollment period – November 15, 2014, through February 15, 2015	
If you want your coverage to start on:	**Your completed application and first month's premium must be received by:**
January 1, 2015	November 15, 2014 – December 18, 2014
February 1, 2015	December 19, 2014 – January 18, 2015
March 1, 2015	January 19, 2015 – February 15, 2015

Enrolling during a special enrollment period

You may change or apply for health care coverage during an annual open enrollment period. Outside of the open enrollment period, you may enroll or change your coverage if you experience a situation known as a triggering event. For example, if you get married, have a baby, or lose coverage because you lose your job – all triggering events – you will have a special enrollment period. If your triggering event occurs during open enrollment, you also will have a special enrollment period and your health coverage effective date may vary from open enrollment effective dates.

Generally, a special enrollment period lasts 60 days after the triggering event occurs. That means if you've experienced a triggering event, you have 60 days from the date of the triggering event to change or apply for health care coverage for yourself and/or your dependent. In some situations, if you are aware of a triggering event that will occur in the future, you may be able to apply for new coverage prior to the triggering event. For example, if you know you will lose coverage, you have 60 days before your loss of coverage and 60 days after your loss of coverage to apply for health coverage. Please refer to the chart for effective dates on page 12.

You have many important decisions to make about your health care coverage, and we're committed to helping you understand how these changes will impact you and your family. If you have any questions, we're here to help.

For more detailed information on your specific special event, please call **1-800-494-5314.**

Triggering events

Loss of health care coverage:

If you lose health plan coverage because you didn't pay your premiums or contributions or because your plan was rescinded, these do not qualify as triggering events. This special enrollment period begins 60 days before the loss of coverage and lasts 60 days after the loss of coverage.

1. **You lose your employer health plan coverage for the following reasons:**
   - You lose your job.
   - Your work hours are reduced, so you no longer qualify for health coverage.
   - The person who covers you on his/her employer health plan dies.
   - You are a dependent on the employer's health plan and your marital status changes due to a legal separation or divorce, so your eligibility as a dependent ends.
   - You lose eligibility for coverage through your employer because you no longer live or work in the service area, and no other group health coverage is available to you.
   - You or your dependent meets or exceeds the maximum lifetime benefits of your health plan because of one specific claim.
   - You are part of a group of employees who are no longer offered coverage from your employer.
   - A dependent child has a birthday and no longer qualifies as a dependent on his/her parent's health plan.
   - Your employer stops contributing premium payments for your group health coverage.
   - Your COBRA coverage is exhausted.
   - Your retiree coverage is terminated or substantially eliminated when your employer declares federal Chapter 11 bankruptcy.
   - You lose your eligibility for coverage because the person who covered you on the employer health plan becomes entitled to Medicare.
2. **Your individual plan, Medicaid, Medicare, or other governmental coverage (but not a special Medicaid program) ends.**

Gaining or becoming a dependent:

You have a baby, adopt a child, or get married. Placement of a foster child is also a triggering event if your plan includes coverage for a foster child. You do not need to be a current member to purchase a health plan for you or your family if you experience this triggering event.

Permanent relocation:

You moved to a new location and have a different choice of health plans, or you were recently released from incarceration.

Change in eligibility for federal financial assistance through Maryland Health Connection:

Your income level changes and, as a result, you qualify or no longer qualify for federal tax credits. Your eligibility to enroll in a health plan with reduced costs (cost-share reduction) changes. For more information about eligibility for federal financial assistance, visit marylandhealthconnection.gov or call 1-855-642-8572. You can also call us at **1-800-494-5314.**

Your eligibility for your employer health coverage changes:

Your employer discontinues or changes your current coverage options so that you become newly eligible for federal financial assistance for premium payments.

Immigration status change:*

You were not previously entitled to enroll in health plan coverage through Maryland Health Connection because you were not lawfully present in the United States. You may only enroll in a plan offered through Maryland Health Connection. For more information about enrolling, visit marylandhealthconnection.gov or call 1-855-642-8572. You can also call us at **1-800-494-5314.**

*If you or your dependent experienced this triggering event, you can only enroll in or change health plan coverage through Maryland Health Connection.

Coverage as an American Indian/ Native Alaskan:*

Maryland Health Connection determines that you are eligible for a special enrollment period each month to enroll in or change health plan coverage through Maryland Health Connection. You may **only** do this through Maryland Health Connection. For information about enrolling through Maryland Health Connection, visit marylandhealthconnection.gov or call 1-855-642-8572. You can also call us at **1-800-494-5314.**

Determination by Maryland Health Connection:

Maryland Health Connection determines that you are entitled to a special enrollment period due to extraordinary circumstances, an error, misrepresentation or inaction of Maryland Health Connection, or for any other reason that Maryland Health Connection may determine in accordance with applicable law.

Triggering-event confirmation required

If you are a new applicant, you will need to provide the triggering event and date of the event under Step 1 on your Application for Health Coverage form.

If you are a current Kaiser Permanente member and want to change your plan due to a triggering event, we'll need a completed Application for Health Coverage form.

Applying online

- If you are a new applicant applying online, you will need to provide your triggering event and date of the event during the online application process. You must apply within 60 days of your triggering event. In some instances, you may apply 60 days before your triggering event occurs so you don't lose health care coverage.

Applying by mail or fax

New applicants

- If you are sending in a paper application, we must receive your paper application within 60 days of your triggering event. You will need to provide your triggering event and the date of your event on your paper application. Your paper application must be received with your first month's premium. In some instances, you may apply 60 days before your triggering event occurs so you don't lose health care coverage.
- Mail or fax your Application for Health Coverage form within 60 days of your triggering event. Be sure to include your first month's premium. Checks must be mailed and cannot be faxed.
- If you apply close to the end of your special enrollment period, be sure we receive your Application for Health Coverage form before your special enrollment period ends.

Current Kaiser Permanente members

- You must submit a completed application.
- Mail or fax your completed application before the end of your special enrollment period.
- If you apply close to the end of your special enrollment period, be sure we receive your application before your special enrollment period ends.

By submitting a signed application, you are confirming that a triggering event occurred. If we decide that the triggering event did not occur, we may take legal action, including, but not limited to, terminating your coverage retroactively.

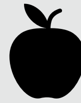
*If you or your dependent experienced this triggering event, you can only enroll in or change health plan coverage through Maryland Health Connection.

Effective dates

Your coverage start date will depend on the triggering event that you experience. Please review this chart to see your effective date.

Type	Receipt of application	Effective date
Loss of health care coverage or change in eligibility for employer coverage due to changes in employer coverage	On or before the last date of coverage	First day of the month following the last date of coverage
	After loss of coverage or change in employer coverage: between the 1st and the 18th of the month	First day of the following month
	After loss of coverage or change in employer coverage: between the 19th and the last day of the month	First day of the second following month
Marriage	Any day of the month	First day of the month following receipt of application
Birth, adoption, or placement for adoption or foster care	Any day of the month	Date of birth, adoption, or placement for adoption or foster care
Permanent relocation, release from incarceration, change in eligibility for federal financial assistance, change in employer coverage, change in immigration status, or status as an American Indian/Native Alaskan	Between the 1st and 18th of the month	First day of the following month
	Between the 19th and the last day of the month	First day of the second following month
Determination by Maryland Health Connection	Any day of the month	Any day of the month as determined by Maryland Health Connection, including a retroactive date

Simple steps to enroll



1. Choose a plan

Pick the plan that's right for you. You can cover your entire family under the same plan or separate plans.

2. Confirm your rate area

Check the "Working out your rate" section on page 24 to see whether your home ZIP code is listed. If it isn't, call us at **1-800-494-5314,** or contact your agent or broker.

3. See if you're eligible for federal financial assistance

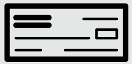
You may be eligible for federal financial assistance from the federal government for your 2015 Kaiser Permanente health plan. If you qualify, the federal government will pay any federal financial assistance to Kaiser Permanente on your behalf. Help may be available for:

- Monthly premiums
- Out-of-pocket costs, such as copayments, coinsurance, or deductibles

See "You may qualify for federal financial assistance" on page 20 for more information.
If you're eligible, you must purchase your Kaiser Permanente plan through Maryland Health Connection to get assistance. If you're not eligible, continue to step 4.

4. Complete your application

Complete an online application at **buykp.org/apply** or use a paper application. If you're working with an agent or broker, be sure to complete that section of the application.



5. Select your payment method

Payment for your first month's coverage by check, money order, debit card, or credit card is required with your application.

6. Sign the application form

Please make sure you've signed everywhere indicated on the application. If your application is missing any information, signatures, documentation, or payment, this may delay your effective date or cancel your application.

7. Submit the application form with payment and all necessary documentation

- **Online:** For the fastest response, enroll online today at **buykp.org/apply**. Or, if you're working with an agent or broker, use the personalized link he or she has provided.
- **Fax: 301-388-1615**
- **Mail:** Membership Administration Dept./KPIF 5W
  Kaiser Permanente
  2101 East Jefferson St., Suite 100
  Rockville, MD 20852–9995

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

Comparing health plans

Bronze, Silver, Gold, Platinum, and Catastrophic – there are different types of plans that work in different ways, depending on how you want to pay for services. You can choose one plan for your entire family or separate plans for different family members. If your family members choose different plans, each plan will have a separate deductible and out-of-pocket maximum.

All our plans include no-charge preventive care

No matter which Kaiser Permanente plan you choose, there is no charge for preventive care. This kind of care can help keep you healthy by providing an early alert for many health conditions. That way, they can be treated before they become serious.

Here are some examples of preventive care services:

- Routine preventive physical exams
- Well-child exams (under 24 months)
- Well-woman visits
- Annual flu shots
- Routine preventive laboratory tests
- Autism screenings
- Mammogram screenings
- Contraceptive care and counseling
- Breastfeeding support

For a complete list of our preventive care services, visit **kp.org/prevention**.

Our copayment plans

KP MD Gold 0/20/Dental/PedDental

KP MD Platinum 0/10/Dental/PedDental

Copayment plans have set fees for many covered services and no deductibles.

- With copayments, you know in advance how much you'll pay for things like doctor's office visits.

How it works*

Let's say you hurt your ankle. You visit your primary care doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

- With the KP MD Gold 0/20/Dental/PedDental copayment plan, you would pay a separate copayment or coinsurance for each of the covered services you received. You do not have to reach a deductible.
- In this case, you would pay a $20 copay for the doctor's office visit, a $20 copay for the X-ray, and a $10 copay for the generic drug.
- Your copays and coinsurance would contribute to your out-of-pocket maximum.

*Please note this is only an example of how a plan works. See the "Health plan benefit highlights" chart starting on page 21 for more detailed information.

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

Our deductible plans

KP MD Gold 1000/20/Dental/PedDental

KP MD Silver 1500/30/Dental/PedDental

KP MD Silver 2500/30/Dental/PedDental

KP MD Bronze 4500/50/Dental/PedDental

KP MD Catastrophic 6600/0/Dental/PedDental

Deductible plans have lower monthly rates. If you need care, you'll usually pay full charge for most covered services until you reach a set amount known as your *deductible*.

Deductible plans with family coverage have both an individual deductible and a family deductible. That means that one member of the family can meet the lower individual deductible and be eligible for coinsurance or copayments before the higher family deductible is satisfied. Similarly, one family member can meet the individual out-of-pocket maximum before the family out-of-pocket maximum is met.

- Once you've reached your deductible, you'll pay a copayment or coinsurance for most covered services for the rest of the contract year until you reach your out-of-pocket maximum.
- Most preventive care services will be covered at no charge even before you reach your deductible.

How it works*

Let's say you hurt your ankle. You visit your primary care doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP MD Silver 1500/30/Dental/PedDental deductible plan, you would have to pay $1,500 out of pocket before being eligible to pay only a copay or coinsurance for certain covered services.

- However, both our Silver deductible plans offer generic drugs, X-rays, and some office visits for just a copay before the deductible is met.
- So, in this example, your doctor's office visit, X-ray, and prescription would be available for a copay before you reach your deductible.
- You would just pay a $30 copay for the doctor's office visit, a $30 copay for the X-ray, and a $15 copay for the generic drug.
- These copays would contribute toward your out-of-pocket maximum but not toward your deductible.
- All the charges you pay for covered services, including all copays, coinsurance, and deductible payments, apply to your out-of-pocket maximum.

*Please note this is only an example of how a plan works. See the "Health plan benefit highlights" chart starting on page 21 for more detailed information.

Our HSA-qualified deductible plans

KP MD Silver 1750/25%/HSA/Dental/PedDental

KP MD Bronze 4500/50/HSA/Dental/PedDental

KP MD Bronze 5000/30%/HSA/Dental/PedDental

With HSA-qualified deductible plans, you can open a health savings account (HSA) that allows you to pay for qualified medical expenses with tax-deductible or pretax dollars.

- You can contribute tax-deductible or pretax dollars into an HSA, and use this money to help pay for eligible medical expenses, such as copayments, coinsurance, and deductible payments for services covered under your health plan.
- You can also use your HSA dollars for services that may not be covered under your health plan, such as eyeglasses and laser eye surgery, dental care, acupuncture, and chiropractic services. For a complete list of qualified medical expenses, see Publication 502, Medical and Dental Expenses, at irs.gov.
- Tax references relate to federal income tax only. For more information, consult your financial or tax adviser. To learn more about health savings accounts, visit irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

The HSA-qualified deductible plans for families

Deductibles and out-of-pocket maximums work differently in our traditional deductible plans versus our HSA-qualified deductible plans for family coverage.

Under our HSA-qualified deductible family plans, there is no individual member deductible or out-of-pocket maximum. Instead, all plans have a family deductible and out-of-pocket maximum, which can be met by the expenses of one or more family members toward a combined family deductible and out-of-pocket maximum. Once the combined expenses of all covered family members reach the applicable deductible or out-of-pocket maximum, the deductible or out-of-pocket maximum will be considered satisfied for all family members for the remainder of the contract year.

How it works*

Let's say you hurt your ankle. You visit your primary care doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

- With the KP MD Bronze 4500/50/HSA/Dental/PedDental plan, you would pay full charge for most covered services until you reach your $4,500 deductible.
- However, if you open and fund an HSA, you can pay for your deductible, copays, and coinsurance with tax-deductible or pretax dollars. There is no charge for most preventive care services even before you meet your deductible.
- So, in this example, you pay the first $4,500 of your medical and pharmacy expenses out-of-pocket. However, if you have money available in your HSA, you can be reimbursed from your health savings account. After meeting the $4,500 deductible, you start paying only a copay or coinsurance for most covered services.
- If you haven't met your deductible, you pay full charge for the doctor's office visit, the X-ray, and the medication. If you've already reached your deductible, you pay only a $50 copay for the doctor's office visit, a $50 copay for the X-ray, and a $20 copay for the generic drug.
- All the charges you pay for covered services, including all copays, coinsurance, and deductible payments, apply to your out-of-pocket maximum.

*Please note this is only an example of how a plan works. See the "Health plan benefit highlights" chart starting on page 21 for more detailed information.

Although family members can enroll in different plans, there are some advantages to enrolling family members in the same plan:

- Children can be covered under your plan until they reach age 26, whether or not they're in school, living at home, or away from the family. But they need to be on the same plan as you.
- If you have more than 3 children under age 21 on the same plan, you will only be charged for the 3 oldest. Other children under 21 are covered at no additional cost.
- For example, to determine the rate for a family plan, a family of 6 (2 adults and 4 children under 21) would calculate their rate by adding the rate for both adults plus the rate for each of the 3 oldest children for a combined family rate. The 4th child (youngest) would be no additional cost.
- You may want to consider different plans with different rates for various family members based on your family's needs. However, you may pay more if you have more than 3 children under age 21 who are not covered under the same plan.
- In a deductible family plan, family members' deductible payments contribute to the family deductible. In addition, family members' individual out-of-pocket expenses for covered services contribute to the family out-of-pocket maximum. Note that there are some services that are not subject to the out-of-pocket maximum.

Preventive care at no extra charge

As you review the rates, remember that many preventive care services are available at no charge before you reach your deductible. That means you get a wide range of services that can help you stay healthy — including general immunizations, diabetes and cancer screenings, counseling for smoking and alcohol abuse, and more. For a complete list of preventive care services, visit **kp.org/prevention**.

Dental plans

We emphasize healthy smiles through preventive care. Kaiser Permanente health plans provide essential health benefits, including pediatric dental benefits for those age 18 and younger, in addition to a Preventive Dental Plan for adults age 19 and older. Dental benefits are administered through Dominion Dental Services USA, Inc. (Dominion Dental).

A reason to smile

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

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

Choosing a dentist

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

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

Quality dental care

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

Enhanced adult dental benefits

For an additional premium of $13.43 per month, adults age 19 and over can choose to enroll in an enhanced dental plan that offers orthodontic coverage, a $10 copayment for most preventive care procedures, and even lower fees on more extensive care than the Preventive Dental Plan. To enroll, select the option on your application to enhance your dental coverage with the dental HMO rider.

Pediatric dental

Kaiser Permanente health plans provide essential health benefits for no additional monthly premium, including pediatric dental benefits for those age 18 and younger.

Your medical plan includes pediatric dental benefits for those age 18 and younger. The pediatric dental plan emphasizes healthy smiles through prevention and early detection of dental problems to avoid costly procedures in the future. The combination of predictable costs and no deductibles helps children reach a state of good oral health without facing the high cost of treatment typical of many dental plans. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and Dominion Dental Services USA, Inc. (Dominion), are working together to help you be well, live well, and thrive.

The Pediatric Dental HMO Plan provides coverage for more than 300 dental procedures through one of the largest networks* in the Mid-Atlantic area.†

You pay a $10 copay for each preventive care office visit, which includes:

- Oral evaluation
- Routine cleaning
- Certain X-ray procedures
- Topical fluoride

The preventive care procedures covered on this plan account for almost 90 percent of the most frequently performed services for children.* Other covered dental services are provided at a reduced fee.

To use your pediatric dental benefits, you must first select a dentist from the Dominion network. To select a participating dentist, visit **dominiondental.com/find-a-dentist** or call the Dominion Dental Member Services Department at **1-888-518-5338.** For more information, call our Member Service Contact Center at **301-468-6000** or **1-800-777-7902,** Monday through Friday from 7:30 a.m. to 5 p.m.

*Dominion Dental Services, Inc., based on annual review of utilization data, network survey, and analysis report, 3rd Quarter 2013.
†Mid-Atlantic area includes Washington, D.C., Maryland, and Virginia.

You may qualify for federal financial assistance

If you need help paying for health care, you may qualify for federal financial assistance. Under health care reform, the federal government will provide federal financial assistance for people with qualifying incomes. Here's some information to help you find out whether you may be eligible.

Federal financial assistance is available

You can apply for federal financial assistance from the federal government to help pay for care and coverage under our new 2015 plans.

- Help with premiums and out-of-pocket expenses (deductibles, copayments, coinsurance) will be available only if you buy your Kaiser Permanente plan or any other issuer's plan through Maryland Health Connection.
- If you are eligible, the federal government will pay the financial assistance to us directly.
- Assistance will be on a sliding scale, based on modified adjusted gross income and family size.

Do you qualify for assistance with monthly premiums?

This chart shows the approximate (estimated) family income levels that qualify people for help. The numbers change slightly every year, so it's important to contact us directly. The chart below is just a guide.

NUMBER OF PEOPLE IN HOUSEHOLD	ANNUAL FAMILY INCOME LEVELS TO QUALIFY
1	$46,680 or below
2	$62,920 or below
3	$79,160 or below
4	$95,400 or below
5	$111,640 or below
6	$127,880 or below
7	$144,120 or below
8	$160,360 or below

You can also use our online calculator to find out if you may qualify for federal financial assistance. Just go to **buykp.org**.

What should you do next?

Go to marylandhealthconnection.gov to see if you qualify for assistance. You'll also be able to enroll in one of our plans there.

Please note that if you have the option of receiving health coverage through your employer, you may not be eligible for federal financial assistance.

To avoid being double billed, if you enroll in a plan through Maryland Health Connection, you must cancel your current plan through Kaiser Permanente by calling our Member Service Contact Center on or before the effective date of your new plan.

What if you don't qualify for assistance?

You have 2 choices:

- You can still purchase an ACA-compliant plan through Maryland Health Connection.
- Or, your can enroll in a plan directly with us, your broker, or any other issuer.

Either way, your plan will offer the same benefits and services.

Have questions?

We've got answers. We'll help you decide which plan is best for you, even if you apply through marylandhealthconnection.gov. Call our Member Service Contact Center at **1-800-494-5314** (TTY **711** for the deaf, hard of hearing, or speech impaired), or contact your agent or broker.

Health plan benefit highlights

See the "Health plan benefit highlights" chart starting on the next page for an overview of what you can expect to pay for services under our plans. This will help you understand which one best meets your needs. For traditional deductible plans, keep in mind that most of the amounts shown apply only after you reach your deductible. To get an idea of what you might pay before reaching your deductible, check out our resources at **kp.org/treatmentestimates**.

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

	KP MD Silver 1500/30/Dental/PedDental
Plan type	Deductible
Features	
Individual plan annual deductible (subscriber only)	$1,500
Family plan annual deductible (individual/family)	$1,500/$3,000
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350
Family plan annual out-of-pocket maximum (individual/family)	$6,350/$12,700
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$30 (waived for children under age 5)
Specialty care office visit	$50
Most X-rays	$30
Most lab tests	$30
MRI, CT, PET	$250
Outpatient surgery	30% after deductible
Mental health visit	$30 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications	30% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	30% after deductible
Emergency and urgent care	
Emergency Department visit	$350
Urgent care visit	$50
Prescription drugs	
Plan pharmacy (up to a 30-day supply)	Generic: $15 Preferred brand: $45 Non-preferred brand: 30% After $250 brand deductible per member
Mail-order (up to a 90-day supply)	Generic: $30 Preferred brand: $90 Non-preferred brand: 30% After $250 brand deductible per member

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 charge for most services until you reach $1,500 for yourself or $3,000 for your family. Then you'd start paying copayments (copays) or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during a policy period (usually a year) before your plan starts paying 100 percent for most covered services. In this example, you'd never pay more than $6,350 for yourself and no more than $12,700 for your family for your deductible, copayments, and coinsurance in a contract 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.

Not subject to the deductible

Some services are always covered at 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 not subject to the deductible.

Coinsurance

After reaching your deductible, you may start paying a percentage of the total cost for certain services. Here, you'd pay 30 percent 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 contract year.

Copayment

This is the set amount you pay for certain services, usually after you reach your deductible. In this example, you'd start paying a $350 copay for Emergency Department visits whether or not you have met your deductible. For these plans, there is an out-of-pocket maximum.

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

Health plan benefit highlights

	KP MD Bronze 5000/30%/HSA/ Dental/PedDental	KP MD Bronze 4500/50/HSA/Dental/ PedDental	KP MD Bronze 4500/50/Dental/ PedDental	KP MD Silver 1750/25%/HSA/Dental/ PedDental	KP MD Silver 2500/30/Dental/ PedDental
Plan type	HSA-qualified	HSA-qualified	Deductible	HSA-qualified	Deductible
Features					
Individual plan annual deductible (subscriber only)	$5,000	$4,500	$4,500	$1,750	$2,500
Family plan annual deductible (individual/family)	$10,000/$10,000	$9,000/$9,000	$4,500/$9,000	$3,500/$3,500	$2,500/$5,000
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350	$6,350	$6,350	$5,000	$6,350
Family plan annual out-of-pocket maximum (individual/family)	$12,700/$12,700	$12,700/$12,700	$6,350/$12,700	$10,000/$10,000	$6,350/$12,700
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	30% after deductible	$50 after deductible (waived for children under age 5)	$50 (waived for children under age 5)	25% after deductible	$30 (waived for children under age 5)
Specialty care office visit	30% after deductible	$50 after deductible	$50	25% after deductible	$50
Most X-rays	30% after deductible	$50 after deductible	$50 after deductible	25% after deductible	$30
Most lab tests	30% after deductible	$50 after deductible	$50 after deductible	25% after deductible	$30
MRI, CT, PET	30% after deductible	$500 after deductible	$500 after deductible	25% after deductible	$300
Outpatient surgery	30% after deductible	30% after deductible	20% after deductible	25% after deductible	30% after deductible
Mental health visit	30% after deductible	$50 after deductible (individual therapy)	$50 (individual therapy)	25% after deductible	$30 (individual therapy)
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications	30% after deductible	$500 per day up to 4 days after deductible*	20% after deductible	25% after deductible	30% after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	$500 per day up to 4 days after deductible*	20% after deductible	25% after deductible	30% after deductible
Emergency and urgent care					
Emergency Department visit	30% after deductible	$500 after deductible	20% after deductible	25% after deductible	$400
Urgent care visit	30% after deductible	$50 after deductible	$50	25% after deductible	$50
Prescription drugs					
Plan pharmacy (up to a 30-day supply)	Generic: $20 Preferred brand/ Non-preferred brand: 30% All after deductible	Generic: $20 Preferred brand: $50 Non-preferred brand: 30% All after deductible	Generic: $25/ Preferred brand/ Non-preferred brand: 50% After $500 brand deductible per member	Generic: $15 Preferred brand: $45 Non-preferred brand: 25% All after deductible	Generic: $15 Preferred brand: $45 Non-preferred brand: 30% After $250 brand deductible per member
Mail-order (up to a 90-day supply)	Generic: $40 Preferred brand/ Non-preferred brand: 30% All after deductible	Generic: $40 Preferred brand: $100 Non-preferred brand: 30% All after deductible	Generic: $50/ Preferred brand/ Non-preferred brand: 50% After $500 brand deductible per member	Generic: $30 Preferred brand: $90 Non-preferred brand: 25% All after deductible	Generic: $30 Preferred brand: $90 Non-preferred brand: 30% After $250 brand deductible per member

This is a summary of the most frequently asked-about benefits and their copayments, coinsurance, and deductibles. Detailed information about your plan is in the *Membership Agreement* (form KFHP-NG-KPIF-MD), which will be mailed to you upon enrollment or upon request. To request a copy of the *Membership Agreement* for a particular plan, please call us at 1-800-634-4579 or contact your agent or broker. Most deductibles, copayments, and coinsurance contribute to the out-of-pocket maximum. For a list of exclusions and limitations for the benefits shown, please see the "Exclusions and Limitations" section.

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

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

Health plan benefit highlights

	KP MD Silver 1500/30/Dental/ PedDental	KP MD Gold 1000/20/Dental/ PedDental	KP MD Gold 0/20/Dental/ PedDental	KP MD Platinum 0/10/Dental/ PedDental	KP MD Catastrophic 6600/0/Dental/ PedDental†
Plan type	Deductible	Deductible	Copayment	Copayment	Deductible
Features					
Individual plan annual deductible (subscriber only)	$1,500	$1,000	None	None	$6,600
Family plan annual deductible (individual/family)	$1,500/$3,000	$1,000/$2,000	None/None	None/None	$6,600/$13,200
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350	$6,350	$6,350	$4,000	$6,600
Family plan annual out-of-pocket maximum (individual/family)	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$4,000/$8,000	$6,600/$13,200
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	$30 (waived for children under age 5)	$20 (waived for children under age 5)	$20 (waived for children under age 5)	$10 (waived for children under age 5)	First 3 office visits no charge.†† Additional visits no charge after deductible.
Specialty care office visit	$50	$40	$40	$20	No charge after deductible
Most X-rays	$30	$20	$20	$5	No charge after deductible
Most lab tests	$30	$20	$20	$5	No charge after deductible
MRI, CT, PET	$250	$150	$250	$150	No charge after deductible
Outpatient surgery	30% after deductible	20% after deductible	30%	$100	No charge after deductible
Mental health visit	$30 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)	$10 (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	30% after deductible	20% after deductible	$500 per day up to 4 days**	$250 per day up to 4 days**	No charge after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	$500 per day up to 4 days**	$250 per day up to 4 days**	No charge after deductible
Emergency and urgent care					
Emergency Department visit	$350	$250	$250	$250	No charge after deductible
Urgent care visit	$50	$40	$40	$20	No charge after deductible
Prescription drugs					
Plan pharmacy (up to a 30-day supply)	Generic: $15 Preferred brand: $45 Non-preferred brand: 30% After $250 brand deductible per member	Generic: $10 Preferred brand: $30 Non-preferred brand: 20%	Generic: $10 Preferred brand: $30 Non-preferred brand: 30%	Generic: $10 Preferred brand: $30 Non-preferred brand: $50	No charge after deductible
Mail-order (up to a 90-day supply)	Generic: $30 Preferred brand: $90 Non-preferred brand: 30% After $250 brand deductible per member	Generic: $20 Preferred brand: $60 Non-preferred brand: 20%	Generic: $20 Preferred brand: $60 Non-preferred brand: 30%	Generic: $20 Preferred brand: $60 Non-preferred brand: $100	No charge after deductible

This is a summary of the most frequently asked-about benefits and their copayments, coinsurance, and deductibles. Detailed information about your plan is in the *Membership Agreement* (form KFHP-NG-KPIF-MD), which will be mailed to you upon enrollment or upon request. To request a copy of the *Membership Agreement* for a particular plan, please call us at 1-800-634-4579 or contact your agent or broker. Most deductibles, copayments, and coinsurance contribute to the out-of-pocket maximum. For a list of exclusions and limitations for the benefits shown, please see the "Exclusions and Limitations" section.

†Only applicants under age 30, or applicants age 30 and older who demonstrate financial hardship or lack of affordable coverage, may purchase a KP MD Catastrophic 6600/0/Dental/PedDental plan.

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

††The KP MD Catastrophic 6600/0/Dental/PedDental plan includes three office visits at no charge before you reach your deductible. Office visits include primary or outpatient mental health care.

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

Working out your rate

We're here to help you find the best plan for your needs. Use the following rate chart and plan cost worksheet on page 25 to help you evaluate your plan options.

What determines your rate?

Your rate is based on the following:

- The plan you select
- Where you live, based on your ZIP code
- Your age at the time of your effective date
- If you add an optional dental rider for family members age 19 and older

If you move and change your home ZIP code, your monthly rate may change. If you move to a ZIP code that isn't covered by Kaiser Permanente, your coverage may not continue.

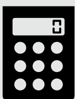
Rates are determined based on each person's age on the plan's effective date, whether they apply individually or as a family. For example, if your 29th birthday is on February 14 and you submit your completed application on January 15, you'll have an effective date of February 1 and the rate for a 28-year-old.

However, if you submit your application on January 16, your effective date will be March 1. Since this is after your birthday, you'll have the rate for a 29-year-old.

Similarly, if you're purchasing coverage for your family, each family member's rate will be based on his or her age on the effective date. (Families are only charged for a maximum of 3 children under age 21 who are applying for the same plan.)

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

Please verify that your ZIP code is listed above. If it isn't, call us at **1-800-494-5314** for information on other rate areas.



Rate calculator

To figure out the total rate for your health plan for you and your family, just follow these steps:

1. List everyone you want to cover:
- Yourself
- Your spouse
- All your adult children ages 21 through 25
- Your children under 21

2. Find your preferred plan in the rate chart on the next page.

3. Find the rate for each family member, based on age.

4. For children who are covered under the same plan, include a rate for the 3 oldest children under 21.

5. Add up the rates.

6. If you are adding the optional dental rider for adults 19 and older, please add $13.43 per adult to your monthly rates.

The worksheet below can help. Go to **buykp.org/apply** or call us or your broker for assistance.

Federal assistance and your rate

If you qualify for federal financial assistance, these rates do not apply to you. The federal government will pay any federal financial assistance to Kaiser Permanente on your behalf. To learn more, read the "You may qualify for federal financial assistance" section on page 20.

Your monthly rate worksheet

Plan choice		A	B	C
Family member name	**Family member age**	**Rate for plan A**	**Rate for plan B**	**Rate for plan C**
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
Optional dental rider (add $13.43 per adult 19 and older)		____ × $13.43 = $________	____ × $13.43 = $________	____ × $13.43 = $________
Total premium rate		$	$	$

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

Do you qualify for financial assistance?

If so, you may pay lower rates than those listed in this chart. See the "You may qualify for federal financial assistance?" section in this booklet for details.

2015 Monthly rates

Please note: Rates do not include the optional adult dental rider. If you change plans, your rate will be based on your and your family members' ages as of the effective date for your new plan.

Age on 2015 effective date	KP MD Bronze 5000/30%/ HSA/Dental/ PedDental	KP MD Bronze 4500/50/ HSA/Dental/ PedDental	KP MD Bronze 4500/50/ Dental/ PedDental	KP MD Silver 1750/25%/ HSA/Dental/ PedDental	KP MD Silver 2500/30/ Dental/ PedDental	KP MD Silver 1500/30/ Dental/ PedDental	KP MD Gold 1000/20/ Dental/ PedDental	KP MD Gold 0/20/Dental/ PedDental	KP MD Platinum 0/10/Dental/ PedDental	KP MD Catastrophic 6600/0/Dental/ PedDental*
<21	$86.99	$89.51	$92.67	$112.48	$118.04	$122.83	$135.80	$151.36	$162.70	$71.45
21	136.99	140.96	145.94	177.14	185.88	193.44	213.86	238.36	256.23	112.52
22	136.99	140.96	145.94	177.14	185.88	193.44	213.86	238.36	256.23	112.52
23	136.99	140.96	145.94	177.14	185.88	193.44	213.86	238.36	256.23	112.52
24	136.99	140.96	145.94	177.14	185.88	193.44	213.86	238.36	256.23	112.52
25	137.54	141.53	146.53	177.84	186.63	194.21	214.72	239.31	257.25	112.97
26	140.28	144.35	149.45	181.39	190.34	198.08	218.99	244.08	262.38	115.22
27	143.57	147.73	152.95	185.64	194.80	202.72	224.13	249.80	268.53	117.92
28	148.91	153.23	158.64	192.55	202.05	210.27	232.47	259.09	278.52	122.31
29	153.29	157.74	163.31	198.21	208.00	216.46	239.31	266.72	286.72	125.91
30	155.48	159.99	165.64	201.05	210.98	219.55	242.73	270.53	290.82	127.71
31	158.77	163.38	169.15	205.30	215.44	224.19	247.87	276.25	296.97	130.41
32	162.06	166.76	172.65	209.55	219.90	228.84	253.00	281.98	303.12	133.11
33	164.11	168.87	174.84	212.21	222.69	231.74	256.21	285.55	306.96	134.80
34	166.31	171.13	177.17	215.04	225.66	234.83	259.63	289.36	311.06	136.60
35	167.40	172.26	178.34	216.46	227.15	236.38	261.34	291.27	313.11	137.50
36	168.50	173.38	179.51	217.88	228.63	237.93	263.05	293.18	315.16	138.40
37	169.59	174.51	180.68	219.29	230.12	239.48	264.76	295.08	317.21	139.30
38	170.69	175.64	181.84	220.71	231.61	241.02	266.47	296.99	319.26	140.20
39	172.88	177.90	184.18	223.54	234.58	244.12	269.89	300.81	323.36	142.00
40	175.07	180.15	186.51	226.38	237.56	247.21	273.32	304.62	327.46	143.80
41	178.36	183.53	190.02	230.63	242.02	251.85	278.45	310.34	333.61	146.50
42	181.51	186.78	193.37	234.70	246.29	256.30	283.37	315.82	339.50	149.09
43	185.90	191.29	198.04	240.37	252.24	262.49	290.21	323.45	347.70	152.69
44	191.38	196.93	203.88	247.46	259.68	270.23	298.77	332.98	357.95	157.19
45	197.81	203.55	210.74	255.78	268.41	279.32	308.82	344.19	369.99	162.48
46	205.49	211.44	218.91	265.70	278.82	290.16	320.79	357.53	384.34	168.78
47	214.12	220.33	228.11	276.86	290.53	302.34	334.27	372.55	400.48	175.87
48	223.98	230.47	238.62	289.62	303.92	316.27	349.66	389.71	418.93	183.97
49	233.71	240.48	248.98	302.19	317.11	330.00	364.85	406.64	437.12	191.96
50	244.66	251.76	260.65	316.36	331.99	345.48	381.96	425.70	457.62	200.96
51	255.49	262.90	272.18	330.36	346.67	360.76	398.85	444.53	477.86	209.85
52	267.40	275.16	284.88	345.77	362.84	377.59	417.46	465.27	500.15	219.64
53	279.46	287.56	297.72	361.36	379.20	394.61	436.28	486.25	522.70	229.54
54	292.47	300.96	311.59	378.18	396.86	412.99	456.60	508.89	547.04	240.23
55	305.49	314.35	325.45	395.01	414.52	431.36	476.91	531.53	571.39	250.92
56	319.60	328.87	340.48	413.26	433.66	451.29	498.94	556.08	597.78	262.51
57	333.85	343.53	355.66	431.68	452.99	471.41	521.18	580.87	624.42	274.22
58	349.05	359.17	371.86	451.34	473.63	492.88	544.92	607.33	652.87	286.71
59	356.59	366.93	379.89	461.08	483.85	503.52	556.68	620.44	666.96	292.89
60	371.79	382.57	396.09	480.74	504.48	524.99	580.42	646.90	695.40	305.38
61	384.94	396.11	410.10	497.75	522.33	543.56	600.95	669.78	720.00	316.19
62	393.57	404.99	419.29	508.91	534.04	555.74	614.43	684.80	736.14	323.28
63	404.40	416.12	430.82	522.90	548.72	571.03	631.32	703.63	756.38	332.16
64+	410.96	422.88	437.82	531.40	557.64	580.30	641.58	715.06	768.67	337.56

Rates are effective January 1, 2015, through December 31, 2015. For tobacco-user rates, call 1-800-494-5314. If you move, these rates may not apply.

*For the Catastrophic plan, only applicants under age 30, or applicants over age 30 who demonstrate hardship or lack of affordable coverage, may purchase a Catastrophic plan.

Important details and notices

Notice of insurance information practices—Abbreviated version

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

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

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

Exclusions and limitations

The following list contains exclusions and limitations associated with the benefits described in this booklet for copayment plans and deductible and HSA-qualified deductible plans sections.

Exclusions:

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under your Agreement. Additional exclusions that apply only to a particular Service are listed in the description of that Service under Section 3 of your Agreement. When a Service is excluded, all Services related to that excluded Service are also excluded, even if they would otherwise be covered under your Agreement.

- Services that are not medically necessary.
- Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
- Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
- 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.
- Services for which a Member is not legally, or as a customary practice, required to pay in the absence of a Health Benefit Plan.
- Except for the pediatric vision benefit provided in Section 3 - Benefits of your Agreement, 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.
- Personal Care Services and Domiciliary Care Services.
- Services rendered by a Health Care Practitioner who is a Member's spouse, mother, father, daughter, son, brother or sister.
- Experimental Services. This exclusion does not apply to Services covered under clinical trials in Section 3 of this Agreement.
- 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.
- Services to reverse a voluntary sterilization procedure or an adult or a Dependent minor.
- Services for sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.
- Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in Section 3 - Benefits of your Agreement.
- Services incurred before the effective date of coverage for a Member.
- Services incurred after a Member's termination of coverage, except as provided in the Extension of Benefits provision in the Plan Renewal, Termination and Transfer of Membership section of your Agreement.
- Surgery or related Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
- 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.
- 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.
- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.
- Inpatient admissions primarily for diagnostic studies, unless authorized by Health Plan.
- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified under Section 3 - Benefits of your Agreement.
- Travel, whether or not recommended by a Health Care Practitioner, except for covered ambulance Services and air travel in connection with a covered transplant.
- Except for Emergency Services, Services received while the Member is outside the United States.

- Immunizations related to foreign travel.
- Unless otherwise specified Section 3 - Benefits of your Agreement, in the Adult Dental Plan Appendix, or in the Pediatric Dental Plan Appendix of this Agreement, dental work or treatment which 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 months of the accident; and
    d. Dental implants.
- Except as covered under the Adult Dental Plan or in the Pediatric Dental Plan of this Agreement, accidents occurring while and as a result of chewing.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these Services are determined to be medically necessary.
- 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.
- Inpatient admissions primarily for physical therapy, unless authorized by Health Plan.
- Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery.
- Treatment of sexual dysfunction not related to organic disease.
- Services that duplicate benefits provided under federal, state, or local laws, regulations, or programs.
- Nonhuman organs and their implantation.
- Non-replacement fees for blood and blood products.
- Lifestyle improvements, or physical fitness programs, unless included in Section 3 - Benefits of your Agreement.
- Wigs or cranial prosthesis, except for hair prosthesis for a Member whose hair loss was the result of chemotherapy or radiation treatment for cancer.
- Weekend admission charges, except for emergencies and maternity, unless authorized by Health Plan.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical Services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
- 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.
- Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
- 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 Health Plan and is undergoing a covered transplant; and,
    b. Services are not payable by another carrier.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Non-medical ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private Hospital room unless authorized by Health Plan.
- Private duty nursing, unless authorized by Health Plan.
- Any claim, bill, or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by § 1-302 of the Health Occupations Article.

Limitations:

We will use our best efforts to provide or arrange for Members' health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under your Agreement, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Office, and complete or partial destruction of facilities. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group 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 Insurance Commissioner of Maryland.

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, Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

Mental Health and Substance Abuse Exclusions:

- Services by pastoral or marital counselors;
- Therapy for sexual problems;
- Treatment for learning disabilities and intellectual disabilities;
- Telephone therapy;
- Travel time to the member's home to conduct therapy;
- Services rendered or billed by schools, or halfway houses or members of their staffs;
- Marriage counseling; and
- Services that are not medically necessary.

Cardiac Rehabilitation Limitations and Exclusions:

- Services must be provided at a facility approved by the Health Plan that is equipped to provide cardiac rehabilitation.
- Maintenance programs are not covered. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

Pulmonary Rehabilitation Limitations and Exclusions:

- Services must be provided at a facility approved by the Health Plan that is equipped to provide pulmonary rehabilitation.
- Maintenance programs are not covered. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

In vitro fertilization Limitation:

- Coverage is limited to three in vitro fertilization attempts per live birth.

Clinical trials Exclusions:

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

Adult dental services

Exclusions:

The following services are not covered under your dental plan Agreement:

- Services which are covered under worker's compensation or employer's liability laws.
- Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the American Dental Association (ADA) guidelines.
- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3 of the Agreement.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
- Dispensing of drugs, except as may be otherwise covered in your medical plan that is described in the Agreement.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as a Covered Dental Service.
- Services provided by a non-Participating Dental Provider or not pre-authorized by Dental Administrator with the exception of out-of-area emergency or urgent care Covered Dental Services and services obtained pursuant to a referral to a non-participating specialist.

- Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a Dental Specialist who will provide Covered Dental Services.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth which, in the opinion of the attending dentist, is not necessary for the patient's dental health.
- The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
- Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
- Services that cannot be performed because of the general health of the patient.
- Implantation and related restorative procedures.
- Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
- Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
- Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in the Agreement.
- Experimental procedures, implantations, or pharmacological regimens which in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Charges for second opinions, unless pre-authorized.
- Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
- Occlusal guards, except for the purpose of controlling habitual grinding.
- Dental services for children under age 19
- Services related to the treatment of TMD (Temporomandibular disorder).
- Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a specialist who will provide Covered Dental Services.
- Hospitalization for any dental procedure.

Limitations:

Covered dental services are subject to the following limitations:

- Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
- One (1) problem focused exam is covered per calendar year.
- Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to two times per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
- One (1) topical fluoride or fluoride varnish is covered per calendar year.
- Two (2) bitewing x-rays are covered per calendar year.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
- Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
- Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
- Crown and bridge fees 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%.
- Relining and rebasing of dentures is limited to once every 24 months.

- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Root planing or scaling is covered once every 24 months per quadrant.
- Full mouth debridement is limited to once per lifetime.
- Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
- Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
- Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.

Pediatric dental services

Exclusions:

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 the Dental Administrator.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Dental Administrator.
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 the Dental Administrator, such services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Replacement due to loss or theft of prosthetic appliance.
9. Procedures not listed as covered benefits under this Plan.
10. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Health Plan or Dental Administrator under Section III.B above (except for dental emergencies as described in Section V. above; and Continuity of Care for new Members, as described in Section 2).
11. Services performed by a Participating Specialist without a referral from a Participating General Dentist (with the exception of Orthodontics). A referral form is required. Participating dentists should refer to Specialty Care Referral Guidelines.
12. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Dental Administrator. The prophylactic removal of these teeth may be covered subject to review.
13. 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.
14. Non-medically necessary orthodontia and Phase I Treatment for Medically Necessary orthodontia are not covered benefits under this policy. The provider agreements create no liability for payment by the Plan, 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. See limitation #21 concerning Medically Necessary.

Pediatric dental services

Limitations:

1. One (1) evaluation (D0120, D0145, D0150, D0160) is covered two (2) times per calendar year, per patient.
2. One (1) teeth cleaning (D1110 or D1120) is covered two (2) times per calendar year, per patient.
3. One (1) topical fluoride application (D1203 or D1204) 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) and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2).
4. Two (2) bitewing x-rays are covered per calendar year, per patient.
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) and above. No more than one (1) set of x-rays are 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) space maintainer (D1515 or D1525) is covered per 24 months, per patient, per arch (D1510, or D1520) is covered per 24 months, per patient, per quadrant.
8. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
9. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
10. Replacement of a prefabricated resin and stainless steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
11. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
12. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
13. Root canal treatment and retreatment of previous root canal are covered once per lifetime, per tooth.
14. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasy (D4210 or D4211) are limited to one (1) per 24 months, per patient, per quadrant.
15. Full mouth debridement is covered once per 24 months, per patient.
16. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
19. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. General anesthesia is not covered with procedure codes D9230, D9241 or D9242. Intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9220, D9221, D9241 or D9242.
20. Orthodontics is only covered if Medically Necessary as determined by the Dental Administrator. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.

To request a full list of exclusions and limitations, please call Member Services at 301-468-6000 or 1-800-777-7902 (TTY 301-879-6380), from 7:30 a.m. to 9 p.m., Monday through Friday.

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

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