KAISER PERMANENTE®

Kaiser Permanente for Individuals and Families

Healthy together

Care and coverage that fits your life

buykp.org

2019 Enrollment | District of Columbia

Welcome to care that fits your life

Your doctor, your choice

Choose your doctor based on what's important to you. Go to **kp.org/searchdoctors** for details about education, specialties, languages spoken, and more. You can also change doctors at any time.

Convenient cost estimates

Get an idea of what you'll pay before you come in for care. For a personalized estimate based on your plan details, visit **kp.org/costestimates**.

More care options

How you get care is up to you. Choose a phone or video appointment,* email your doctor's office with nonurgent questions, or come see us in person.†

Right care, right time

Get the care you need when you need it with routine, specialty, urgent, and emergency care. If you're ever unsure where to go, call us for 24/7 care advice by phone.

Many services under one roof

Do more in less time. In most of our facilities, you can see your doctor, get a lab test, and pick up prescriptions – all in a single trip.

*When appropriate and available.

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

The right choice for your health

Welcome to your Kaiser Permanente for Individuals and Families enrollment guide. This guide will help you select the right health plan for your needs.

Simple steps to apply

Use this guide to help you find a plan that works for you. Then, apply online or fill out a paper application.

Visit **buykp.org/apply** to compare plans, see if you qualify for federal financial assistance or to calculate your rate.

Important deadline for open enrollment

The open enrollment period for 2019 coverage runs from **November 1, 2018, through December 15, 2018.** You can change or apply for coverage through DC Health Link.

For coverage that starts on January 1, 2019, we must receive your Application for Health Coverage and first month's premium **no later than December 15, 2018.**

Enrolling during a special enrollment period

Are you getting married, having a baby, or losing your health coverage? You may also enroll or change your coverage throughout the year if you have a qualifying life event.

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

Your care, your way

Get care where, when, and how you want it. With more options to choose from, it's easier to stay on top of your health.

Choose how you connect to care

Online	Stay on top of your care at **kp.org**. Once you're registered, you can view your medical record, refill most prescriptions, schedule routine appointments, and more. Email your doctor's office anytime with nonurgent questions. You'll usually get a response within 2 business days.
Video	Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face online. Call us or email your doctor's office to see if video visits are available to you.*
Phone	Have a condition that doesn't require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente doctor.
In person	Most of our locations have many services under one roof, so you can see your doctor, get lab services or X-rays, and pick up a prescription – all in the same trip.
Online wellness tools	Visit **kp.org/healthyliving** for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs.
Discounts for members	Enjoy discounts on products and services that can help you stay healthy – like gym memberships, massage therapy, and more. Explore your options at **kp.org/choosehealthy**.

Some features are availble only when you get care at Kaiser Permanente facilities.

*All video appointments are for certain medical conditions, and for members who are age 18 or older. Routine video visit appointments are with physicians who practice at Kaiser Permanente facilities. During a routine video visit with your doctor, you must be present in Maryland, Virginia, or Washington, D.C. For urgent video visits with a doctor, you may also be located in Florida, North Carolina, West Virginia, or Pennsylvania (available weekdays from 10 a.m. to 10 p.m. and weekends from noon to midnight, Eastern time).

Have questions? Call us at **1-800-494-5314.** • Go to dchealthlink.com. • Or contact your agent or broker.

61116108 DC 2019

Choose your health plan

Understanding health plans

We offer a variety of plans to fit your needs and budget. All of them offer the same quality care, but the way they split the costs is different. Learn more below.

Copay plans

Platinum, Gold

Copay plans are the simplest. You know in advance how much you'll pay for care like doctor visits and prescriptions. This amount is called your **copay.** Your monthly premium is higher, but you'll pay much less when you actually get care.

Deductible plans

Gold, Silver, Bronze

With a deductible plan, your monthly premium is lower, but you'll have to reach a deductible. This means you'll pay the full charges for most covered services until you reach a set amount known as your **deductible.** Then you'll start paying less – just a copay or coinsurance. Depending on your plan, some services, like office visits or prescriptions, may be available at a copay or coinsurance before you meet your deductible.

HSA-qualified deductible plans

Silver, Bronze

HSA-qualified deductible plans are deductible plans with a special feature. With this plan, you can set up a health savings account (HSA) to pay for health costs like copays, coinsurance, and deductible payments. And you won't pay federal taxes on the money in this account.

You can use your HSA anytime to pay for care, including some services that may not be covered by your plan, such as eyeglasses, adult dental care, or chiropractic services.* And if you have money left in your HSA at the end of the year, it will roll over for you to use the next year.

*For a complete list of services you can use your HSA to pay for, see Publication 502, *Medical and Dental Expenses,* at irs.gov.

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Choosing a plan based on your care needs

If you need a lot of care, you may want a plan with a higher monthly rate so that you pay less when you come in for care. If you don't go to the doctor much, you may want a plan with a lower monthly rate, keeping in mind you'll pay more if and when you do get care.

Monthly rate versus out-of-pocket costs

Plan level	What you pay for your monthly rate	What you pay when you get care (Emergency Department visit, lab test, etc.)
Platinum		
Gold		
Silver		
Bronze		

An example of costs when you get care

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

Plan name	Office visit	X-ray	Generic drug
KP DC Gold 0/20/Dental (No deductible)	$20 (waived for children under 5)	$40	$10*
KP DC Silver 2500/30/Dental ($2,500 deductible)	$30 (waived for children under 5)	$50	$15*
KP DC Bronze 6200/20%/HSA/Dental ($6,200 deductible)	20% after deductible	20% after deductible	20% after deductible

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

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

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Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan's benefits. Review the diagram below to help you understand how to read those charts.

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

	KP DC Silver 2500/30/Dental
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$7,750/$15,500
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$30 (waived for children under 5)
Specialty care office visit	$50
Most X-rays	$50
Most lab tests	$30
MRI, CT, PET	35% after deductible
Outpatient surgery	35% after deductible
Mental health visit	$30 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	35% after deductible
Emergency and urgent care	
Emergency Department visit	35% after deductible
Urgent care visit	$50
Prescription drugs (up to a 30-day supply)	
Generic	$15*
Preferred brand	$55 after $750 pharmacy deductible per member*
Non-preferred brand	35% after $750 pharmacy deductible per member
Specialty	35% after $750 pharmacy deductible per member up to $150 maximum per 30-day prescription and $300 maximum per 90-day prescription
Whole health	
Healthy services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $2,500 for yourself or $5,000 for your family. Then you'd start paying copays or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than $7,750 for yourself and no more than $15,500 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they're not subject to the deductible.

Covered before you reach the deductible

With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a $30 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance

After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 35% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd pay a $50 copay for urgent care visits, whether or not you have met your deductible.

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

	KP DC Bronze 6500/60/Dental	KP DC Standard Bronze 6200/20%/ HSA/Dental	KP DC Standard Bronze 6650/50/Dental	KP DC Silver 3200/30%/ HSA/Dental	KP DC Standard Silver 3500/40/Dental	KP DC Silver 2500/30/Dental
Plan type	**Deductible**	**HSA-qualified**	**Deductible**	**HSA-qualified**	**Deductible**	**Deductible**
Features						
Annual medical deductible (individual/family)	$6,500/$13,000	$6,200/$12,400	$6,650/$13,300	$3,200/$6,400	$3,500/$7,000	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$7,900/$15,800	$6,550/$13,100	$7,900/$15,800	$6,000/$12,000	$7,600/$15,200	$7,750/$15,500
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	$60 (waived for children under 5)	20% after deductible	$50	30% after deductible	$40	$30 (waived for children under 5)
Specialty care office visit	$75 after deductible	20% after deductible	$80	30% after deductible	$80	$50
Most X-rays	50% after deductible	20% after deductible	$80 after deductible	30% after deductible	$70	$50
Most lab tests	50% after deductible	20% after deductible	$55 after deductible	30% after deductible	$50	$30
MRI, CT, PET	50% after deductible	20% after deductible	$500 after deductible	30% after deductible	$250	35% after deductible
Outpatient surgery	50% after deductible	20% after deductible	25% after deductible	30% after deductible	20% after deductible	35% after deductible
Mental health visit	$60 (individual therapy)	20% after deductible	$50 (individual therapy)	30% after deductible	$40 (individual therapy)	$30 (individual therapy)
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	50% after deductible	20% after deductible	25% after deductible	30% after deductible	20% after deductible	35% after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	50% after deductible	20% after deductible	25% after deductible	30% after deductible	20% after deductible	35% after deductible
Emergency and urgent care						
Emergency Department visit	50% after deductible	20% after deductible	25% after deductible	30% after deductible	$350 after deductible (copay waived if admitted)	35% after deductible
Urgent care visit	$75 after deductible	$50 after deductible	$100	30% after deductible	$90	$50
Prescription drugs (up to a 30-day supply)						
Generic	$30†	20% after deductible	$25†	$15 after deductible†	$15†	$15†
Preferred brand	50% after $850 pharmacy deductible per member	20% after deductible	$75 after $600 pharmacy deductible per member†	$55 after deductible†	$50 after $250 pharmacy deductible per member†	$55 after $750 pharmacy deductible per member†
Non-preferred brand	50% after $850 pharmacy deductible per member	20% after deductible	$100 after $600 pharmacy deductible per member†	20% after deductible	$70 after $250 pharmacy deductible per member†	35% after $750 pharmacy deductible per member
Specialty	50% after $850 pharmacy deductible per member up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	20% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$150 after $600 pharmacy deductible per member per 30-day prescription & $300 maximum per 90-day prescription	30% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$150 after $250 pharmacy deductible per member per 30-day prescription & $300 maximum per 90-day prescription	35% after $750 pharmacy deductible per member up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription
Whole health						
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)					

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **301-468-6000,** or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 5 days, there is no charge for covered services related to the admission.

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

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

	KP DC Gold 1500/25%/HSA/ Dental	KP DC Gold 1000/20/Dental	KP DC Standard Gold 500/25/Dental	KP DC Gold 0/20/Dental	KP DC Standard Platinum 0/20/Dental	KP DC Catastrophic‡ 7900/0/Dental
Plan type	**HSA-qualified**	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features						
Annual medical deductible (individual/family)	$1,500 (subscriber-only plan) $3,000/$3,000 (family plan)††	$1,000/$2,000	$500/$1,000	None/None	None/None	$7,900/$15,800
Annual out-of-pocket maximum (individual/family)	$4,500/$9,000	$6,850/$13,700	$4,000/$8,000	$6,850/$13,700	$2,000/$4,000	$7,900/$15,800
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	$20 after deductible (copay waived for children under 5)	$20 (waived for children under 5)	$25	$20 (waived for children under 5)	$20	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	$40 after deductible	$40	$50	$40	$40	No charge after deductible
Most X-rays	$40 after deductible	$40	$50	$40	$40	No charge after deductible
Most lab tests	$20 after deductible	$20	$30	$20	$20	No charge after deductible
MRI, CT, PET	25% after deductible	$500	$250	$500	$150	No charge after deductible
Outpatient surgery	25% after deductible	35% after deductible	$600	35%	$250	No charge after deductible
Mental health visit	$20 after deductible (individual therapy)	$20 (individual therapy)	$25 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)	First 3 office visits no charge.** Additional visits no charge after deductible.
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	25% after deductible	35% after deductible	$600 per day up to 5 days after deductible*	35%	$250 per day up to 5 days*	No charge after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	25% after deductible	35% after deductible	$600 per day up to 5 days after deductible*	35%	$250 per day up to 5 days*	No charge after deductible
Emergency and urgent care						
Emergency Department visit	$500 after deductible (copay waived if admitted)	$500 (waived if admitted)	$300 (waived if admitted)	$500 (waived if admitted)	$150 (waived if admitted)	No charge after deductible
Urgent care visit	$40 after deductible	$40	$60	$40	$40	No charge after deductible
Prescription drugs (up to a 30-day supply)						
Generic	$10 after deductible†	$10†	$15†	$10†	$5†	No charge after deductible
Preferred brand	$30 after deductible†	$30†	$50†	$30†	$15†	No charge after deductible
Non-preferred brand	25% after deductible	35%	$70†	35%	$25†	No charge after deductible
Specialty	25% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	35% up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$150 $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	35% up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$100 $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	No charge after deductible
Whole health						
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)					Dental preventive services: $30 for adults; $0 plus office visit fee after deductible for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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*After 5 days, there is no charge for covered services related to the admission.

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

‡Only applicants under age 30, or applicants age 30 and older who provide a certificate from the Health Insurance Marketplace in DC demonstrating hardship or lack of affordable coverage, may purchase a KP DC Catastrophic 7900/0/Dental plan.

**The KP DC Catastrophic 7900/0/Dental plan includes 3 office visits at no charge before you reach your deductible. Office visits include primary or outpatient mental health visits combined.

††For the KP DC Gold 1500/20%/HSA/Dental plan, in a subscriber-only plan, the individual deductible is $1,500. In a family version of the KP DC Gold 1500/25%/HSA/Dental plan, there is no individual member deductible of $1,500. Instead, there is only a family deductible of $3,000 that can be met by one or more family members. Once the combined contribution of all covered family members has reached the applicable deductible of $3,000, the deductible will be satisfied for all family members and they begin paying only the applicable copayments and coinsurance amounts for the remainder of the plan year.

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Cost Share Reduction (CSR) Plans

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

	KP DC Silver 1700/20%/ CSR/HDHP/Dental (3200)	KP DC Silver 500/10%/CSR/ HDHP/Dental (3200)	KP DC Silver 100/5%/CSR/ HDHP/Dental (3200)	KP DC Silver 2200/30/CSR/ Dental (2500)	KP DC Silver 0/10/CSR/ Dental (2500)
Plan type	**Deductible**	**Deductible**	**Deductible**	**Deductible**	**Copayment**
Features					
Annual medical deductible (individual/family)	$1,700/$3,400	$500/$1,000	$100/$200	$2,200/$4,400	None/None
Annual out-of-pocket maximum (individual/family)	$6,000/$12,000	$2,250/$4,500	$2,250/$4,500	$6,300/$12,600	$2,600/$5,200
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	20% after deductible	10% after deductible	5% after deductible	$30 (waived for children under 5)	$10 (waived for children under 5)
Specialty care office visit	20% after deductible	10% after deductible	5% after deductible	$50	$20
Most X-rays	20% after deductible	10% after deductible	5% after deductible	$50	$30
Most lab tests	20% after deductible	10% after deductible	5% after deductible	$30	$20
MRI, CT, PET	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Outpatient surgery	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Mental health visit	20% after deductible	10% after deductible	5% after deductible	$30 (individual therapy)	$10 (individual therapy)
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Emergency and urgent care					
Emergency Department visit	20% after deductible	10% after deductible	5% after deductible	35% after deductible	30%
Urgent care visit	20% after deductible	10% after deductible	5% after deductible	$50	$20
Prescription drugs (up to a 30-day supply)					
Generic	$15 after deductible†	$10 after deductible†	$5 after deductible†	$15†	$10†
Preferred brand	$55 after deductible†	$35 after deductible†	$10 after deductible†	$55 after $750 pharmacy deductible per member†	$50†
Non-preferred brand	20% after deductible	10% after deductible	5% after deductible	35% after $750 pharmacy deductible per member	30%
Specialty	30% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	10% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	5% after deductible up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	35% after $750 pharmacy deductible per member up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	30% up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription
Whole health					
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)				

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

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Cost Share Reduction (CSR) Plans

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	KP DC Silver 0/5/CSR/ Dental (2500)	KP DC Standard Silver 3000/40/CSR/ Dental (3500)	KP DC Standard Silver 100/15/CSR/ Dental (3500)	KP DC Standard Silver 0/5/CSR/ Dental (3500)
Plan type	**Copayment**	**Deductible**	**Deductible**	**Copayment**
Features				
Annual medical deductible (individual/family)	None/None	$3,000/$6,000	$100/$200	None/None
Annual out-of-pocket maximum (individual/family)	$1,800/$3,600	$6,300/$12,600	$2,600/$5,200	$2,250/$4,500
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$5 (waived for children under 5)	$40	$15	$5
Specialty care office visit	$5	$65	$25	$10
Most X-rays	$10	$70	$35	$5
Most lab tests	$5	$50	$20	$5
MRI, CT, PET	10%	$250	$150	$50
Outpatient surgery	10%	20% after deductible	20% after deductible	10%
Mental health visit	$5 (individual therapy)	$40 (individual therapy)	$15 (individual therapy)	$5 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10%	20% after deductible	20% after deductible	10%
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	10%	20% after deductible	20% after deductible	10%
Emergency and urgent care				
Emergency Department visit	10%	$350 after deductible (copay waived if admitted)	$250 after deductible (copay waived if admitted)	$250 (copay waived if admitted)
Urgent care visit	$5	$65	$25	$10
Prescription drugs (up to a 30-day supply)				
Generic	$5†	$15†	$15†	$5†
Preferred brand	$10†	$50 after $250 pharmacy deductible per member†	$50†	$10†
Non-preferred brand	10%	$70 after $250 pharmacy deductible per member†	$70†	$35†
Specialty	20% up to $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$150 after $250 pharmacy deductible per member per 30-day prescription & $300 maximum per 90-day prescription	$150 $150 maximum per 30-day prescription & $300 maximum per 90-day prescription	$100 $150 maximum per 30-day prescription & $300 maximum per 90-day prescription
Whole health				
Healthy Services	Dental preventive services: $30 for adults; $0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)			

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **301-468-6000,** or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

*After 5 days, there is no charge for covered services related to the admission.

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

Find your rate

Use the monthly rates charts on the following pages, or apply on **buykp.org/apply** to have your rate calculated automatically. Along with your monthly rate, consider what you'll need to pay when you get care.

What determines your rate?

Your rate is based on the following:

- The plan you select
- Where you live, based on your county and ZIP code
- Your age on your start date (effective date)
- If you qualify for federal financial assistance. Visit **buykp.org/apply** or call us at **1-800-494-5314** to see if you may qualify.

Interested in a family plan?

Find the rate for each family member, based on his or her age on the start date.

- You
- Your spouse/domestic partner
- All adult children 21 through 25
- Your 3 oldest children under 21

If you have more than 3 children under 21, you only have to pay for the 3 oldest. The other children under 21 will be covered at no charge.

The rates in the monthly rates charts apply to the ZIP codes below. Please check that your ZIP code is listed below. If it isn't, call us at **1-800-494-5314** for information on other rate areas.

ZIP codes for Washington, D.C.

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

KAISER PERMANENTE®

2019 Monthly rates

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

Age on 2019 effective date	KP DC Bronze 6500/60/Dental	KP DC Standard Bronze 6200/20%/ HSA/Dental	KP DC Standard Bronze 6650/50/ Dental	KP DC Silver 3200/30%/HSA/ Dental	KP DC Standard Silver 3500/40/ Dental	KP DC Silver 2500/30/Dental	KP DC Gold 1500/25%/HSA/ Dental	KP DC Gold 1000/20/Dental
0–14	$237.37	$241.13	$253.24	$263.82	$268.36	$277.31	$285.51	$286.54
15	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
16	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
17	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
18	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
19	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
20	237.37	241.13	253.24	263.82	268.36	277.31	285.51	286.54
21	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
22	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
23	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
24	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
25	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
26	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
27	263.87	268.05	281.51	293.27	298.31	308.27	317.38	318.52
28	270.04	274.32	288.09	300.12	305.29	315.47	324.80	325.97
29	275.84	280.22	294.28	306.58	311.85	322.26	331.79	332.98
30	282.74	287.22	301.64	314.24	319.65	330.31	340.08	341.30
31	290.00	294.60	309.39	322.31	327.86	338.79	348.81	350.07
32	296.53	301.23	316.35	329.57	335.24	346.43	356.67	357.95
33	303.43	308.24	323.71	337.24	343.04	354.48	364.97	366.28
34	310.69	315.61	331.46	345.30	351.25	362.96	373.70	375.04
35	317.95	322.99	339.20	353.37	359.45	371.44	382.43	383.80
36	325.21	330.36	346.94	361.44	367.66	379.93	391.16	392.56
37	332.47	337.74	354.69	369.51	375.87	388.41	399.89	401.33
38	336.46	341.79	358.95	373.94	380.38	393.07	404.69	406.15
39	340.45	345.85	363.21	378.38	384.89	397.73	409.50	410.97
40	353.88	359.49	377.53	393.31	400.08	413.42	425.65	427.18
41	367.67	373.50	392.25	408.64	415.67	429.54	442.24	443.83
42	382.19	388.25	407.74	424.77	432.08	446.50	459.70	461.35
43	397.07	403.37	423.61	441.31	448.91	463.88	477.60	479.31
44	412.68	419.22	440.26	458.66	466.55	482.11	496.37	498.15
45	428.65	435.44	457.30	476.41	484.60	500.77	515.58	517.43
46	445.34	452.40	475.11	494.96	503.48	520.28	535.66	537.58
47	462.77	470.10	493.70	514.33	523.18	540.63	556.62	558.61
48	480.91	488.54	513.06	534.49	543.69	561.83	578.45	580.52
49	499.79	507.71	533.20	555.47	565.03	583.88	601.15	603.30
50	519.39	527.62	554.11	577.25	587.19	606.78	624.72	626.96
51	539.71	548.27	575.79	599.84	610.17	630.52	649.17	651.50
52	560.76	569.65	598.25	623.24	633.97	655.12	674.49	676.91
53	582.54	591.78	621.48	647.44	658.59	680.56	700.68	703.20
54	605.41	615.00	645.88	672.86	684.44	707.27	728.19	730.80
55	629.00	638.97	671.04	699.08	711.11	734.83	756.56	759.28
56	653.68	664.04	697.37	726.51	739.01	763.67	786.25	789.07
57	679.09	689.85	724.48	754.75	767.73	793.35	816.81	819.74
58	705.58	716.77	752.75	784.19	797.69	824.30	848.68	851.72
59	733.17	744.79	782.17	814.85	828.87	856.53	881.86	885.02
60	761.84	773.92	812.76	846.72	861.29	890.03	916.35	919.63
61	791.60	804.15	844.52	879.80	894.93	924.80	952.14	955.56
62	791.60	804.15	844.52	879.80	894.93	924.80	952.14	955.56
63	791.60	804.15	844.52	879.80	894.93	924.80	952.14	955.56
64+	791.60	804.15	844.52	879.80	894.93	924.80	952.14	955.56

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

KAISER PERMANENTE®

2019 Monthly rates

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

Age on 2019 effective date	KP DC Standard Gold 500/25/Dental	KP DC Gold 0/20/ Dental	KP DC Standard Platinum 0/20/ Dental	KP DC Catastrophic 7900/0/Dental	KP DC Silver 1700/20%/ CSR/HDHP/Dental (3200) KP DC Silver 500/10%/ CSR/HDHP/Dental (3200) KP DC Silver 100/5%/CSR/HDHP/ Dental (3200)	KP DC Silver 2200/30/CSR/Dental (2500) KP DC Silver 0/10/CSR/ Dental (2500) KP DC Silver 0/5/CSR/ Dental (2500)	KP DC Standard Silver 3000/40/CSR/ Dental (3500) KP DC Standard Silver 100/15/CSR/ Dental (3500) KP DC Standard Silver 0/5/CSR/ Dental (3500)
0–14	$302.66	$300.77	$338.90	$191.63	$263.82	$277.31	$268.36
15	302.66	300.77	338.90	191.63	263.82	277.31	268.36
16	302.66	300.77	338.90	191.63	263.82	277.31	268.36
17	302.66	300.77	338.90	191.63	263.82	277.31	268.36
18	302.66	300.77	338.90	191.63	263.82	277.31	268.36
19	302.66	300.77	338.90	191.63	263.82	277.31	268.36
20	302.66	300.77	338.90	191.63	263.82	277.31	268.36
21	336.44	334.34	376.73	213.02	293.27	308.27	298.31
22	336.44	334.34	376.73	213.02	293.27	308.27	298.31
23	336.44	334.34	376.73	213.02	293.27	308.27	298.31
24	336.44	334.34	376.73	213.02	293.27	308.27	298.31
25	336.44	334.34	376.73	213.02	293.27	308.27	298.31
26	336.44	334.34	376.73	213.02	293.27	308.27	298.31
27	336.44	334.34	376.73	213.02	293.27	308.27	298.31
28	344.31	342.16	385.54	218.00	300.12	315.47	305.29
29	351.72	349.52	393.83	222.69	306.58	322.26	311.85
30	360.51	358.25	403.68	228.25	314.24	330.31	319.65
31	369.76	367.45	414.04	234.11	322.31	338.79	327.86
32	378.10	375.73	423.37	239.39	329.57	346.43	335.24
33	386.89	384.47	433.21	244.96	337.24	354.48	343.04
34	396.14	393.67	443.58	250.82	345.30	362.96	351.25
35	405.40	402.86	453.94	256.68	353.37	371.44	359.45
36	414.65	412.06	464.31	262.54	361.44	379.93	367.66
37	423.91	421.26	474.67	268.40	369.51	388.41	375.87
38	429.00	426.32	480.37	271.62	373.94	393.07	380.38
39	434.09	431.38	486.07	274.84	378.38	397.73	384.89
40	451.21	448.39	505.24	285.68	393.31	413.42	400.08
41	468.80	465.87	524.93	296.82	408.64	429.54	415.67
42	487.31	484.26	545.66	308.54	424.77	446.50	432.08
43	506.29	503.12	566.91	320.55	441.31	463.88	448.91
44	526.19	522.89	589.19	333.15	458.66	482.11	466.55
45	546.55	543.13	611.99	346.04	476.41	500.77	484.60
46	567.84	564.28	635.83	359.52	494.96	520.28	503.48
47	590.05	586.36	660.70	373.59	514.33	540.63	523.18
48	613.19	609.35	686.61	388.24	534.49	561.83	543.69
49	637.25	633.27	713.56	403.47	555.47	583.88	565.03
50	662.24	658.10	741.54	419.30	577.25	606.78	587.19
51	688.16	683.86	770.56	435.71	599.84	630.52	610.17
52	715.00	710.53	800.62	452.70	623.24	655.12	633.97
53	742.77	738.12	831.71	470.28	647.44	680.56	658.59
54	771.92	767.10	864.35	488.74	672.86	707.27	684.44
55	802.01	796.99	898.04	507.79	699.08	734.83	711.11
56	833.48	828.26	933.27	527.71	726.51	763.67	739.01
57	865.87	860.45	969.55	548.22	754.75	793.35	767.73
58	899.65	894.02	1,007.38	569.61	784.19	824.30	797.69
59	934.82	928.98	1,046.76	591.88	814.85	856.53	828.87
60	971.38	965.31	1,087.70	615.03	846.72	890.03	861.29
61	1,009.32	1,003.02	1,130.19	639.05	879.80	924.80	894.93
62	1,009.32	1,003.02	1,130.19	639.05	879.80	924.80	894.93
63	1,009.32	1,003.02	1,130.19	639.05	879.80	924.80	894.93
64+	1,009.32	1,003.02	1,130.19	639.05	879.80	924.80	894.93

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

Learn about dental and vision coverage

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

A reason to smile

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

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

Choosing a dentist

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

To locate a participating provider, please visit **dominiondental.com/kaiserdentists** or call Dominion at **1-855-733-7524.**

Quality dental care

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

Essential vision care

You can get optometry services like routine eye exams, glaucoma screenings, and cataract screenings without a referral from your personal physician.

You'll need a referral to get care from an ophthalmologist. Many Kaiser Permanente medical centers have a vision center where you can have exams and purchase quality eyewear and contact lenses. To locate a medical center with a vision center, visit **kp.org/facilities**.

For information about vision coverage and limitations:

- Call Member Services at **1-800-777-7902** (TTY **711**), Monday through Friday from 7:30 a.m. to 9 p.m. (except holidays).
- Refer to your *Membership Agreement and Evidence of Coverage*.
- Register at **kp.org** and read a summary of your benefits online through My Health Manager.

Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and administered by Dominion National.

Have questions? Call us at **1-800-494-5314.** • Go to dchealthlink.com. • Or contact your agent or broker.

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Find a facility near you

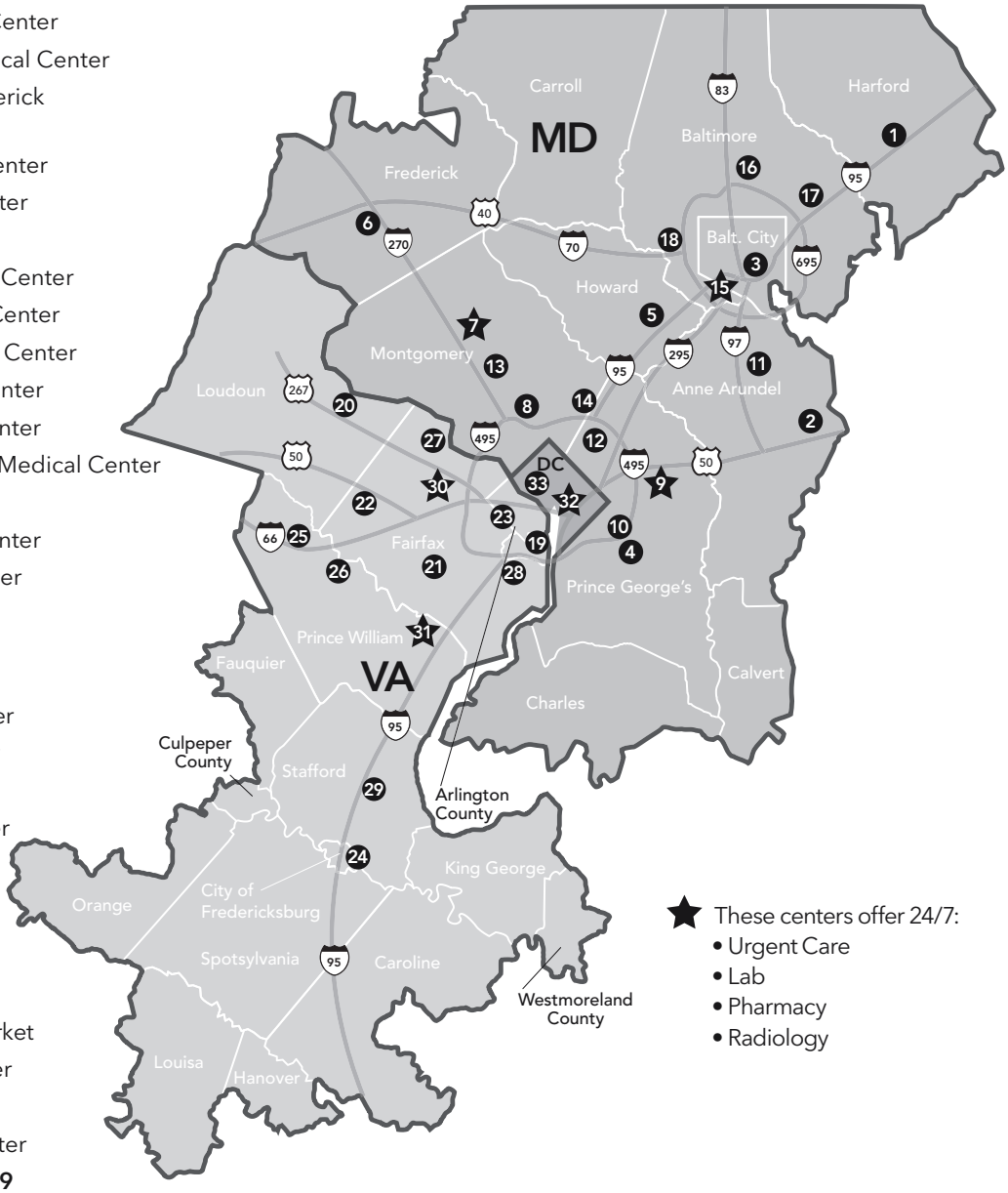
Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or visit **kp.org/facilities** to find the one nearest you.

1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Camp Springs Medical Center
5 Columbia Gateway Medical Center
6 Kaiser Permanente Frederick Medical Center
7 Gaithersburg Medical Center
8 Kensington Medical Center
9 Largo Medical Center
10 Marlow Heights Medical Center
11 North Arundel Medical Center
12 Prince George's Medical Center
13 Shady Grove Medical Center
14 Silver Spring Medical Center
15 South Baltimore County Medical Center
16 Towson Medical Center
17 White Marsh Medical Center
18 Woodlawn Medical Center

Virginia

19 **OPENING SPRING 2019** Alexandria Medical Center
20 Ashburn Medical Center
21 Burke Medical Center
22 Fair Oaks Medical Center
23 Falls Church Medical Center
24 Fredericksburg Medical Center
25 **OPENING LATE 2019** Medical center in Haymarket
26 Manassas Medical Center
27 Reston Medical Center
28 Springfield Medical Center
29 **OPENING SUMMER 2019** Medical center in Stafford
30 Tysons Corner Medical Center
31 Woodbridge Medical Center

32 Kaiser Permanente Capitol Hill Medical Center
33 Northwest DC Medical Office Building



Have questions? Call us at **1-800-494-5314.** • Go to dchealthlink.com. • Or contact your agent or broker.

Exclusions, limitations, and reductions

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

Exclusions

The benefits described in this section are covered only when:

1. A Plan Physician determines that the Services are Medically Necessary;
2. The Services are provided, prescribed, authorized or directed by a Plan Physician; and
   a. You receive the Services at a Plan Facility, Plan Provider or contracted Skilled Nursing Facility inside our Service Area (except when specifically noted otherwise within this Agreement); or
   b. You agree to have Services delivered through a patient centered medical homes program for individuals with chronic conditions, serious illnesses or complex health care needs. This includes associated costs for coordination of care, such as:
      i. Liaison Services between the individual and the Health Care Provider, nurse coordinator and the care coordination team;
      ii. Creation and supervision of a care plan;
      iii. Education of the Member and their family regarding the Member's disease, treatment compliance and self-care techniques; and
      iv. Assistance with coordination of care, including arranging consultations with Specialists and obtaining Medically Necessary supplies and Services, including community resources.

You must receive all covered Services from Plan Providers inside our Service Area except for:

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in *Section 2: How to Get the Care You Need*;
4. Approved referrals, as described under *Getting a Referral in Section 2: How to Get the Care You Need*, including referrals for clinical trials as described in this section.

Note: Some benefits may require payment of a Copayment, Coinsurance or Deductible. Refer to the *Summary of Services and Cost Shares Appendix* for the Cost Sharing requirements that apply to the covered Services contained within the *List of Benefits* in this section.

This Agreement does not pay for all health care Services, even if they are Medically Necessary. Your right to benefits is limited to the covered Services contained within this contract. To view your benefits, see the *List of Benefits* in this section.

Out-of-Pocket Maximums

The Out-of-Pocket Maximum is the limit to the total amount that you must pay for covered Services in a calendar year. The total amount includes what you have paid for your Coinsurance, Copayments, and Deductible, if applicable. Once you reach this limit, you do not pay any additional Coinsurance or Copayments for Services covered under this Agreement for the remainder of the calendar year.

See *Appendix B* for the exact dollar amount of your Out-of-Pocket Maximum.

The Health Plan will keep accurate records of your Copayment and Coinsurance expenses. We will notify you when you reach your Out-of-Pocket Maximum. Such notification will be given no later than thirty (30) days after the Out-of-Pocket Maximum is reached. The Health Plan will not charge additional Copayments or Coinsurance for Services for the remainder of the calendar year. The Health Plan will promptly refund any Copayment and Coinsurance you have paid for Services after the Out-of-Pocket Maximum is reached.

When you pay for Services, ask for and keep receipts. You will need them for your tax records and to verify against our records the payments credited toward the Out-of-Pocket Maximum. When you have questions about the status of your Out-of-Pocket Maximum, contact us at [1-800-777-7902].

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under *Exclusions* in this section.

Accidental Dental Injury Services

Benefit-Specific Exclusions:

Services provided by non-Plan Providers

Ambulance Services

Benefit-Specific Exclusions:

1. Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
2. Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

Anesthesia for Dental Services

Benefit-Specific Exclusion:

The dentist's or Specialist's professional Services.

Blood, Blood Products and Their Administration

Benefit-Specific Limitation:

Member recipients must be designated at the time of procurement of cord blood.

Benefit-Specific Exclusion:

Directed blood donations.

Chemical Dependency and Mental Health Services

Benefit-Specific Exclusions:

1. Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse or drug addiction, except as described above.
2. Services for Members who, in the opinion of the Plan Provider, are seeking Services for other than therapeutic purposes.
3. Psychological testing for ability, aptitude, intelligence or interest.
4. Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
5. Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

Clinical Trials

Benefit-Specific Exclusions:

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

Diabetic Equipment, Supplies and Self-Management

Benefit-Specific Limitations:

Diabetic equipment and supplies are limited to the Health Plan's preferred equipment and supplies unless the equipment or supply:

1. Was prescribed by a Plan Provider; and
   a. There is no equivalent preferred equipment or supply available; or
   b. An equivalent preferred equipment or supply has:
      i. Been ineffective in treating the disease or condition of the Member; or
      ii. Caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

Drugs, Supplies and Supplements

Benefit-Specific Exclusions:

1. Drugs for:
   a. Which a prescription is not required by law;
   b. The treatment of sexual dysfunction disorders;
   c. The treatment of infertility; and
2. Drugs, supplies and supplements that can be self-administered or do not require administration or observation by medical personnel.

Durable Medical Equipment

Benefit-Specific Exclusions:

1. Comfort, convenience or luxury equipment or features.

2. Exercise or hygiene equipment.
3. Non-medical items such as sauna baths or elevators.
4. Modifications to your home or car.
5. Electronic monitors of the heart or lungs, except infant apnea monitors.
6. Prosthetic and orthotic devices, except as covered under Prosthetic Devices.

Emergency Services

Benefit-Specific Limitations:

1. Notification: If you receive care at a hospital emergency room and/or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, not later than fortyeight (48) hours of any emergency room visit or admission or on the first working day following the emergency room visit or admission, whichever is later, unless it was not reasonably possible to notify us. If admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
2. Continuing or follow-up treatment: We do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the non-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan Service Area.
3. Hospital Observation: Transfer to an observation bed or observation status does not qualify as an admission to a hospital, and your emergency room visit Copayment, if applicable, will not be waived.

Family Planning Services

Benefit-Specific Limitation:

We cover up to a maximum of (2) voluntary terminations of pregnancy during a calendar year.

Habilitative Services

Benefit-Specific Exclusions:

1. Assistive technology Services and devices.
2. Services provided through federal, state or local early intervention programs, including school programs.
3. Services not preauthorized by the Health Plan.
4. Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.

Hearing Tests

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy.

Home Health Services

Benefit-Specific Exclusions:

1. Custodial care (see definition in this section).
2. Routine administration of oral medications, eye drops or ointments.
3. General maintenance care of colostomy, ileostomy, and ureterostomy.
4. Medical supplies or dressings applied by a Member or family caregiver.
5. Corrective appliances, artificial aids and orthopedic devices.
6. Homemaker Services.
7. Services that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
8. Transportation and delivery Service costs of Durable Medical Equipment, medications and drugs, medical supplies and supplements to the home.

Hospice Care Services

Benefit-Specific Limitations:

Hospice Care Services are limited to a maximum of 180 days per eligibility period. The hospice eligibility period begins on the first date hospice care Services are rendered and terminates 180 days later or upon the death of the terminally ill Member, if sooner. If the

Member requires an extension of the eligibility period, we will extend the eligibility period on an individual case basis, if we determine that the Member's prognosis and continued need for Services are consistent with a program of hospice care Services.

Infertility Diagnostic Services

Benefit-Specific Exclusions:

1. Artificial insemination, in vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure.
2. Infertility drugs used in assisted reproductive technology (ART) procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
3. Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
4. Fallopian scar revision surgery.

Medical Foods

Benefit-Specific Exclusion:

Medical food for treatment of any condition other than an inherited metabolic disease.

Oral Surgery

Benefit-Specific Exclusions:

1. Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
2. Lab fees associated with cysts that are considered dental under our standards.
3. Orthodontic Services.
4. Dental appliances.

Preventive Health Care Services

Benefit-Specific Limitations:

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services.

1. Monitoring a chronic disease;
2. Follow-up Services after you have been diagnosed with a disease;
3. Testing and diagnosis of a specific disease, not listed above under preventive health care Services, for which you have been determined to be at high risk for contracting based on factors determined by national standards.
4. Services when you show signs or symptoms of a specific disease or disease process;
5. Non-routine gynecological visits.
6. Lab, imaging, and other ancillary Services not included in routine prenatal care.
7. Non-preventive Services performed in conjunction with a sterilization.
8. Lab, imaging, and other ancillary Services associated with male sterilizations. Lab, imaging, and other ancillary Services that are an integral part of a preventive Service, such as a preventive colonoscopy or female sterilization, will be covered without cost sharing.
9. Complications that arise after a sterilization procedure.
10. Treatment of a medical condition or problem identified during the course of the preventive screening exam.
11. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
12. Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
13. Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

Note: Refer to Outpatient Care for coverage of non-preventive diagnostic tests. The applicable Copayment or Coinsurance will apply to any Services listed under these limitations.

Prosthetic Devices

Benefit-Specific Limitation:

Coverage for mastectomy bras is limited to a maximum of two (2) per calendar year.

Benefit-Specific Exclusions:

1. Services not preauthorized by the Health Plan;
2. Internally implanted breast prosthesis for cosmetic purposes;
3. Repair or replacement of prosthetic devices due to loss or misuse;
4. Microprocessor and robotic controlled external prosthetics and orthotics not covered under the Medicare Coverage Database;
5. Multifocal intraocular lens implants;
6. More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices;
7. Dental prostheses, devices and appliances, except as specifically provided in this section, or as provided under an Adult Dental Plan Rider or a Pediatric Dental Plan Rider, if applicable;
8. Hearing aids;
9. Corrective lenses and eyeglasses;
10. Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above;
11. Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts; and
12. Comfort, convenience or luxury equipment or features.

Reconstructive Surgery

Benefit-Specific Exclusions:

Cosmetic surgery, plastic surgery or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in physical function. Examples of excluded cosmetic dermatology Services are:

1. Removal of moles or other benign skin growths for appearance only;
2. Chemical peels; and
3. Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

Routine Foot Care

Benefit-Specific Limitation:

Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Benefit-Specific Exclusions:

Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

Skilled Nursing Facility Care

Benefit-Specific Exclusions:

1. Custodial care (definition in this section).
2. Domiciliary care.

Telemedicine Services

Benefit-Specific Exclusion:

Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

Therapy and Rehabilitation Services

Benefit-Specific Limitations:

1. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
2. Speech therapy is limited to treatment for speech impairments due to injury or illness.
3. Physical therapy is limited to the restoration of a physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided under Early Intervention Services in this section.
4. The limitations listed immediately above for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Benefit-Specific Exclusions:

1. Long-term rehabilitation therapy.
2. Except as provided for cardiac and pulmonary rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a ninety (90)-day period.

Transplant Services

Benefit-Specific Exclusion:

Services related to non-human or artificial organs and their implantation.

Urgent Care Services

Benefit-Specific Exclusion:

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

Vision Services

Benefit-Specific Exclusions:

1. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
2. Eye exercises;
3. Orthoptic (eye training) therapy;
4. Eyeglass lenses and eyeglass frames;* and
5. All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits, except as otherwise covered under this section.*
6. Sunglasses without corrective lenses unless Medically Necessary;*
7. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;*
8. Non-corrective contact lenses;* and
9. Replacement of lost or broken lenses or frames.*

*Note: Exclusions #4–#9 do not apply to HMO and DHMO plans.

Exclusions

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

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section.

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

1. **Certain Alternative Medical Services**, except when used for anesthesia, Acupuncture Services and any other Services of an Acupuncturist, Naturopath, and Massage Therapist.
2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, licensing, or disability determinations; or
   c. On court-order or required for parole or probation.
3. **Cosmetic Services**, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.
4. **Custodial Care**, meaning assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
5. **Disposable Supplies** for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices not specifically listed as covered in the *List of Benefits* in this Section.
6. **Durable Medical Equipment**, except for Services covered under "Durable Medical Equipment" in the *List of Benefits* in this Section.
7. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.

8. **Experimental or Investigational Services:** Except as covered under Clinical Trials in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:
   a. It cannot be legally marketed in the United States without the approval of the federal Food and Drug Administration (FDA) and such approval has not been granted; or
   b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
   c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of Services; or
   d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

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

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

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

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

(Surrogacy Health Services). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

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

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

Kaiser Permanente
[Attention: Patient Financial Services
c/o Surrogacy Coordinator
2101 E. Jefferson Street, 4 East
Rockville, MD 20852]

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

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

15. **Travel and Lodging Expenses**[.][, except in some situations when a Plan Physician refers you to a provider outside of our Service Area, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines].*

    *Note: The exception to Travel and Lodging Expenses applies to HDHP plans only.

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

    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or

    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employers' liability law.

Limitations

We will make our best efforts to provide or arrange for your health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Office; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide the Services covered under this Agreement, the Health Plan, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente's Medical Group Plan Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a Member in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under *Getting a Second Opinion in Section 2: How to Get the Care You Need*. If you still refuse to accept the recommended Services, the Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

NONDISCRIMINATION NOTICE

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

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

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

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

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

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

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes

Notes

Notes

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Online tools designed to make your life easier

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

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