

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5018 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary or call 1-855-249-5018 (TTY: 711) to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall deductible ? | \$1,000 Individual / \$2,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and services indicated in chart starting on page 2. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 Individual / \$6,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.kp.org or call 1-855-249-5018 (TTY: 711) for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network providers might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | Yes, but you may self-refer to certain specialists . | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|--|--|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 / visit, deductible does not apply | Not covered | Waived for child under age 5 |
| | Specialist visit | \$30 / visit, deductible does not apply | Not covered | None |
| | Preventive care/ screening/ immunization | No charge, deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$20 / visit, deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRI's) | 10% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|--|---|--|---|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.kp.org.</p> | Generic drugs | \$10 / prescription at Plan Pharmacy and Mail Order ; \$30 / prescription at Participating Pharmacy , deductible does not apply | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs. |
| | Preferred brand drugs | \$30 / prescription at Plan Pharmacy and Mail Order ; \$50 / prescription at Participating Pharmacy , deductible does not apply | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs. |
| | Non-preferred brand drugs | \$50 / prescription at Plan Pharmacy and Mail Order ; \$75 / prescription at Participating Pharmacy , deductible does not apply | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs. |
| | Specialty drugs | Applicable Generic, Preferred, and Non-Preferred copayments , deductible does not apply | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for oral chemotherapy drugs. |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not covered | None |
| | Physician/surgeon fees | 10% coinsurance | Not covered | None |
| <p>If you need immediate medical attention</p> | Emergency room care | \$100 / visit, deductible does not apply | \$100 / visit, deductible does not apply | Waived if admitted as inpatient |
| | Emergency medical transportation | \$100 / encounter, deductible does not apply | \$100 / encounter, deductible does not apply | None |
| | Urgent care | \$30 / visit, deductible does not apply | \$30 / visit, deductible does not apply | Non- plan providers are covered only outside the service area |
| <p>If you have a hospital stay</p> | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | Emergency admissions covered for non- plan providers |
| | Physician/surgeon fee | 10% coinsurance | Not covered | Emergency services covered for non- plan providers |

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|--|---|--|---|---|
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 / individual visit; \$10 / group visit, deductible does not apply | Not covered | Mental/Behavioral health: No coverage for psychological and neuropsychological testing, for ability, aptitude, intelligence, or interest; Substance abuse: None |
| | Inpatient services | 10% coinsurance | Not covered | None |
| If you are pregnant | Office visits | No charge, deductible does not apply | Not covered | Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 10% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | Not covered | None |
| | Rehabilitation services | \$30 / visit, deductible does not apply | Not covered | Outpatient: Limited to 30 visits of PT/OT/ST / year / injury / incident / condition |
| | Habilitation services | \$30 / visit, deductible does not apply | Not covered | For children until the end of the month in which the child turns age 19 |
| | Skilled nursing care | 10% coinsurance | Not covered | Coverage is limited to 100 days / year |
| | Durable medical equipment | No charge | Not covered | None |
| | Hospice service | 10% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay Plan Provider (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|----------------------------|---|---|--|
| If your child needs dental or eye care | Children's eye exam | \$20 / Optometrist visit; \$30 / Ophthalmologist visit, deductible does not apply | Not covered | None |
| | Children's glasses | No charge, deductible does not apply | Not covered | 1 pair of glasses / year limited to single or bifocal lenses or 1st purchase of contact lenses / year or 2 pair / eye / year medically necessary contacts (from select group of frames and contacts) |
| | Children's dental check-up | Not covered | Not covered | No coverage for Dental Care |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine Foot Care |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture (20 visit limit/year) • Bariatric surgery • Chiropractic care (20 visit limit/year) | <ul style="list-style-type: none"> • Hearing aids (1/ear/36 months. After the end of the month in which you turn age 19, there is a \$1,000 benefit max) • Infertility treatment (IVF: 3 attempts/live birth with a lifetime max of \$100,000) | <ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

| | |
|-----------------------------------|---|
| Kaiser Permanente Member Services | 1-855-249-5018 (TTY: 711) or www.kp.org/memberservices |
|-----------------------------------|---|

| | |
|--|---|
| Department of Labor's Employee Benefits Security Administration | 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or www.cciio.cms.gov |
| Maryland Department of Insurance | 1-877-261-8807 or www.oag.state.md.us |

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5018 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5018 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5018 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5018 (TTY: 711)

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery) | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | Mia's Simple Fracture (in-network emergency room visit and follow up care) |
|---|--|---|
|---|--|---|

| | | | | | |
|---|--------|---|--------|---|--------|
| ■ The plan's overall deductible | \$1000 | ■ The plan's overall deductible | \$1000 | ■ The plan's overall deductible | \$1000 |
| ■ Specialist copayment | \$30 | ■ Specialist copayment | \$30 | ■ Specialist copayment | \$30 |
| ■ Hospital (facility) coinsurance | 10% | ■ Hospital (facility) coinsurance | 10% | ■ Hospital (facility) coinsurance | 10% |
| ■ Other (blood work) copayment | \$20 | ■ Other (blood work) copayment | \$20 | ■ Other (x-ray) copayment | \$20 |

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Durable medical equipment (*crutches*)
 Diagnostic test (*x-ray*)
 Rehabilitation services (*physical therapy*)

| Total Example Cost | \$12,800 | Total Example Cost | \$7,400 | Total Example Cost | \$1,900 |
|-----------------------------------|----------------|-----------------------------------|----------------|-----------------------------------|----------------|
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$1,000 | Deductibles | \$0 | Deductibles | \$400 |
| Copays | \$30 | Copays | \$1,000 | Copays | \$600 |
| Coinsurance | \$800 | Coinsurance | \$200 | Coinsurance | \$0 |
| What isn't covered | | What isn't covered | | What isn't covered | |
| Limits or exclusions | \$60 | Limits or exclusions | \$60 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,890 | The total Joe would pay is | \$1,260 | The total Mia would pay is | \$1,000 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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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) ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። 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).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jù ké m̀ Bàsòò-wùdù-po-nyò jù ní, níí, à wuɖu kà kò dò po-poò béìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: 711)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় 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, dijiri gi. 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 yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' 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).

اردو (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).