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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Not Applicable.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$6,850 Individual / $13,700 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-855-249-5018 (TTY: 711) for a list of network providers.</td>
<td>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 provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, but you may self-refer to certain specialists.</td>
<td>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.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td>Non-Plan Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 / visit</td>
<td>Not Covered</td>
<td>Copayment waived for children under age 5.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 / visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$65 / visit</td>
<td>Not Covered</td>
<td>Lab is $20 / visit.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRI's)</td>
<td>$500 / test</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 / prescription</td>
<td>Not Covered</td>
<td>Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs or contraceptives.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$50 / prescription</td>
<td>Not Covered</td>
<td>Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs or contraceptives.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>Up to 30-day or 90-day supply. No charge for preventive drugs or contraceptives.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>Up to a $250 max per 30-day supply, or up to a $500 max per 90-day supply at KP Pharmacy or Mail Order.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay Plan Provider (You will pay the least)</td>
<td>What You Will Pay Non-Plan Provider (You will pay the most)</td>
<td>Limitations, Exceptions &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$500 / visit</td>
<td>$500 / visit</td>
<td>Copay waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Non-licensed ambulance services not covered</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 / visit</td>
<td>$40 / visit</td>
<td>Non-plan providers are covered only outside the service area.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 / visit</td>
<td>Not Covered</td>
<td>Group Therapy is $10 / visit.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>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.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay Plan Provider (You will pay the least)</th>
<th>What You Will Pay Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: 35% coinsurance; Outpatient: $30 / visit</td>
<td>Not Covered</td>
<td>Inpatient: None; Outpatient: Limited to 30 visits each for PT/OT/ST/year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30 / visit</td>
<td>Not Covered</td>
<td>Limited to 30 visits each for PT/OT/ST/year. Early Intervention: No visit limits for certain children under age 3. ABA not covered.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>Limited to 100 days per stay.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>35% coinsurance</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>One exam per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>1 pair glasses/yr OR 1st purchase of contact lenses/yr OR 2 pair/eye/yr medically necessary contacts (select group of frames and contacts)</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Discount fees apply to other services. $10 office visit copay applies / visit.</td>
</tr>
</tbody>
</table>

#### 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.)

- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services** (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care with limits (Limited to 30 visits / year. The visit limit applies separately for Habilitative and Rehabilitative Services.)
- Dental Care with limits (Adult)
- Infertility Treatment with limits (Diagnostic Services)
- Private-Duty Nursing with limits
- Routine Eye Care (Adult)
- Voluntary Termination of Pregnancy
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 agency in the chart below.

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

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Member Services</td>
<td>1-855-249-5018 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a></td>
<td></td>
</tr>
<tr>
<td>Virginia Department of Insurance</td>
<td>1-877-310-6560 or <a href="http://www.scc.virginia.gov/boi">www.scc.virginia.gov/boi</a></td>
<td></td>
</tr>
</tbody>
</table>

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, kwiijiho 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>35%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Other (blood work) copayment</strong></td>
<td><strong>Other (blood work) copayment</strong></td>
<td><strong>Other (x-ray) copayment</strong></td>
</tr>
<tr>
<td>$65</td>
<td>$65</td>
<td>$65</td>
</tr>
</tbody>
</table>

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*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
<th>$7,400</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$0</th>
<th>$0</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copays</td>
<td>$30</td>
<td>$1300</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3200</td>
<td>$600</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>$60</th>
<th>$60</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Peg would pay is $3290

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$30</th>
<th>$1300</th>
<th>$800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>$60</th>
<th>$60</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Joe would pay is $1960

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$3200</th>
<th>$600</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copays</td>
<td>$800</td>
<td>$600</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>$0</th>
<th>$0</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Mia would pay is $900

The plan would be responsible for the other costs of these EXAMPLE covered services.
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.


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).

লক্ষ্য (Bassa) করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, ভাষা সহায়তা প্রতিষ্ঠানের সাহায্য অর্জন করতে পারেন। যেতে বাংলা ভাষায় ১-৮০০-৭৭৭-৭৯০ (TTY: ৭১১)।

Bà pomysł (Farsi) توجه: اگر به زبان فارسی فکر می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌شود. 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:શું ઉપલભ થાય કે તમારા માટે ઉપલભ છે. કેલ 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।


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.


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).


ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการร่วมเหลือทางภาษาได้ฟรี 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 ہونگے۔ کال کریں 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).