KAISER PERMANENTE®: KP VA Gold 0 Ded/500 RxDed/Vision

Coverage for: Individual/Family | Plan Type: HMO

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 4000 Garden City Drive Hyattsville, MD 20785

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 https://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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	Yes. Rx Deductible (Doesn't apply to Generic Tier 1 and Preferred Brand Tier 2 drugs): $500 Individual in network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$9,200 Individual / $18,400 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?	Copayments on certain services, premiums, and health care this plan doesn't cover.	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 provider 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	Not Covered	Copayment waived for children under age 5.
	Specialist visit	$40 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $65 / visit; Lab: $30 / visit	Not Covered	None
	Imaging (CT/PET scans, MRI's)	$500 / test	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	$10 / prescription (retail) deductible does not apply; $15 / prescription (mail order) deductible does not apply.	Not Covered	Up to 30-day supply (retail); up to 90-day supply (mail order). Formulary preventive drugs and contraceptives in all tiers are no charge. Subject to formulary guidelines.
	Preferred brand drugs (Tier 2)	$55 / prescription (retail) deductible does not apply; $83 / prescription (mail order) deductible does not apply.	Not Covered	Up to 30-day supply (retail); up to 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs (Tier 3)	45% coinsurance after drug deductible	Not Covered	Up to 30-day supply (retail); up to 90-day supply (mail order). Subject to formulary guidelines.
	Specialty drugs (Tier 4)	50% coinsurance after drug deductible	Not Covered	Up to 30-day supply. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not Covered	None
	Physician/surgeon fees	35% 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 you need immediate medical attention	Emergency room care	$500 / visit	$500 / visit	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$40 / visit	$40 / visit	Non-plan providers are not covered inside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not Covered	None
	Physician/surgeon fee	35% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / individual visit; $10 / group visit.	Not Covered	All other outpatient services are No charge.
	Inpatient services	35% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	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	35% coinsurance	Not Covered	None
	Childbirth/delivery facility services	35% 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 you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	None
	Rehabilitation services	Outpatient: $40 / visit; Inpatient: 35% coinsurance	Not Covered	Outpatient: Physical, Occupational, and Speech therapies 30-visit limit / therapy / condition / year; Inpatient: None
	Habilitation services	$40 / visit	Not Covered	Physical, Occupational, and Speech therapies 30-visit limit / therapy / condition / year. Early Intervention: No visit limits for certain children under age 3.
	Skilled nursing care	35% coinsurance	Not Covered	100-day limit / stay.
	Durable medical equipment	35% coinsurance	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One exam per year.
	Children's glasses	No Charge	Not Covered	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)
	Children's dental check-up	$5 / visit	Not Covered	Limited to members up to the end of the month in which the member turns 19.

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
- Dental Care (Adult)
- 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.) • Hearing Aids with limits (Under age 19 1 aid / ear / 24 months up to $1500)	• 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 on how 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:

Kaiser Permanente Member Services	1-855-249-5018 (TTY: 711) or www.kp.org/memberservices
Virginia Bureau of Insurance	1-877-310-6560 or www.scc.virginia.gov/boi

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

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)

TRADITIONAL 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)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-249-5018 (TTY: 711) uff

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

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5018 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5018 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 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)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**35%**
Other (blood work) copayment	**$30**

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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**35%**
Other (blood work) copayment	**$30**

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*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**35%**
Other (x-ray) copayment	**$65**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
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, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille and accessible electronic formats
- Provides 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**.

This notice is available at **https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice**

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yɛ́, mbi èyɛm. Wɔ nàŋ **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)-এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ़्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください（TTY: **711**）。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902**로 전화해 주세요(TTY: **711**).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**)**.**

اُردو (Urdu) توجہ: اگر آپ اردو بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn iṣẹ́ ìrànlọ́wọ́ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

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