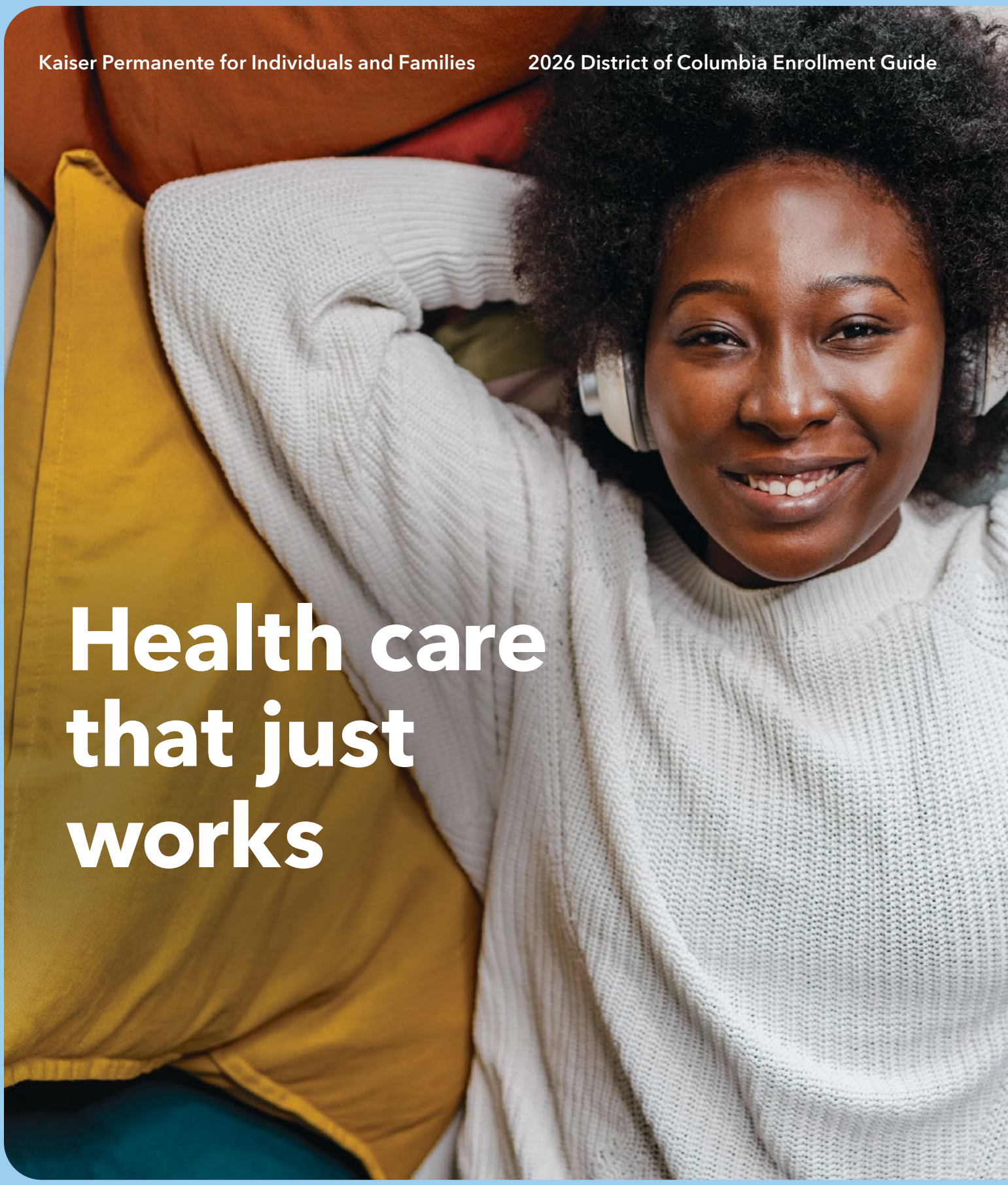


Health care that just works

Get started at **buykp.org**

KAISER PERMANENTE®

Experience simpler, smarter health care

When your health needs are handled under one plan, you get:

- **High-quality in-person and virtual care experiences**
- **24/7 access to care wherever you are**
- **Support for your mental health and wellness**
- **High-quality preventive, primary, and specialty care**

Go where you feel like your best self

We can help you get to your healthy place – no matter where it is. Kaiser Permanente care feels easier and faster, with the help of connected caregivers, more ways to get care, and support for a healthy mind and body.

Important open enrollment dates for 2026

- The open enrollment period for 2026 coverage runs from **November 1, 2025,** through **January 31, 2026.**
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through DC Health Link.
- For coverage that starts on **January 1, 2026,** we must receive your application for health coverage no later than **December 15, 2025.**

Enrolling during a special enrollment period

- Are you getting married, moving, or losing your health coverage? You can also enroll or change your coverage at other times throughout the year if you have a qualifying life event.
- Visit **kp.org/specialenrollment** for a list of qualifying life events and instructions.

Want to talk? We're here to help.

A Kaiser Permanente enrollment specialist can answer your questions – like where to get care or what healthy extras are included. Call **1-800-494-5314** (TTY **711**).

Combined care and coverage is everything

Your doctors, hospitals, and health plan benefits should work together to give you world-class care, when and where you need it.

From preventive, primary, and virtual care to pharmacy, labs, and mental health support – we put it all together to make your health care work for you.

That's why members stay with Kaiser Permanente nearly twice as long as other health plans.[1]

Discover how we can help you live your best life at **kp.org/learnthebasics**.

“This was my first appointment with Dr. Rieple, and I could not be more impressed. She made me feel like I was the most important person on her schedule.”

–Michele, Kaiser Permanente member

Timely, convenient in-person and virtual care

Get the care you need, when you need it. The Kaiser Permanente app makes it easier to manage your care online or connect with your care team on demand. And with our widespread network of locations, specialists, and services, you can get timely lab results and primary care appointments close to home.

24/7 virtual care

Visit **kp.org** or use our app to talk to a clinician 24/7 by phone or video.[2] You can also email your care team, view most lab results, and more.

Mail-order pharmacy

Refill prescriptions online, in person, or over the phone – with same-day pickup and same-day or next-day home delivery for most prescriptions.[3]

Care while traveling

If you're planning to travel, we can help with vaccinations, prescriptions, and more. You also have access to urgent and emergency care worldwide – not just at Kaiser Permanente facilities.

Urgent care away from home

If you need urgent care outside a Kaiser Permanente state – California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, or Washington, D.C. – you can go to the nearest CVS MinuteClinic, Concentra urgent care, or urgent care facility.[4]

Support for your body and mind

Members can get help with depression, anxiety, addiction, and mental or emotional health — without a referral for mental health care within Kaiser Permanente. Explore individual and group therapy, health classes, self-care resources, and more.[5]

Resources for your everyday wellness

Take advantage of classes, services, and programs to help you achieve your health goals.[6]

- Wellness coaching
- Fitness programs
- Gym memberships
- Acupuncture, massage therapy, and chiropractic care

Our members are:

5x
more likely to be screened for depression[7]

Nearly 2x
more likely to respond to treatment[7]

Care that's world class

With most plans, you get preventive care at no extra cost. If you need specialty care – for maternity, cancer care, heart health, or anything else – you have access to cutting-edge technology and advanced, evidence-based care. You can also change your doctor at any time, so you always have a health partner you know and trust.

- **Recognized excellence in stroke and heart disease care:** The American Heart Association and American Stroke Association's Get With The Guidelines® program has recognized 38 of our medical centers for commitment to excellence in the treatment of stroke or heart disease.[8]
- **Quality cancer care:** Kaiser Permanente Mid-Atlantic States received an accreditation with commendation from the Commission on Cancer. The accreditation recognizes that our cancer care exceeds requirements designed by the American College of Surgeons.

We guide you every step of the way

Your health history with Kaiser Permanente lives in your electronic health record.

Your care team guides you through appointments and referrals.

Your health record is available to you and your care team 24/7.

Your care team lets you know when to schedule checkups and tests.

"You have enough stressors in your life. So at Kaiser Permanente we make sure health care isn't one of them."

–Dr. Khushboo Mehta

Choosing your health plan

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

Virtual plans

With a virtual plan, your monthly premium is lower, and you'll start most care with a virtual visit. Connect to care how you want – choose from 24/7 online chat or advice phone line, e-visit, scheduled video visit, phone appointment, or email for nonurgent issues, all at no additional cost. You'll get the care and prescriptions you need, or help finding in-person care.

Copay plans

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 get care.

KP Plus plans

KP Plus members receive high-quality, comprehensive care from Kaiser Permanente doctors. They can also choose to see any licensed provider outside Kaiser Permanente for certain covered services – with up to 10 out-of-network outpatient medical visits per year, including doctor visits, lab, and radiology, as well as up to 5 out-of-network pharmacy refills. Out-of-network payments don't accrue toward in-plan deductibles or out-of-pocket maximums.

Visit **choiceproducts-midatlantic.kp.org/hmo-dhmo-plus** to learn more.

Deductible plans

With a deductible plan, your monthly premium is lower, but you'll need to pay the full charges for most covered services until you reach a set amount, known as your deductible. Then you'll start paying less – 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 reach your deductible.

HSA-qualified high deductible health plans

HSA-qualified deductible plans are deductible plans with a special feature that gives you the option of setting up a health savings account (HSA) to pay for eligible health care costs, including copays, coinsurance, and deductible payments. 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, like eyeglasses for adults, adult dental care, or chiropractic services[9]. 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.

New for 2026: Most bronze plans can be paired with a health savings account. Learn more at **healthy.kaiserpermanente.org/pages/hsa-overview**.

Explore dental coverage

Kaiser Permanente Smile dental coverage offers enhanced benefits to support improved oral health for whole-body wellness.

Visit **kp.org/dental/mas** to learn more.

Vision benefits

At Kaiser Permanente, each member's electronic health record connects eye care to overall care, so their personal doctor knows when they're due for a comprehensive eye exam and can even schedule an appointment for a glaucoma screening and other vision concerns. Of course, members can also be examined for eyeglasses or contact lens prescriptions – that's where Vision Essentials by Kaiser Permanente comes in.

Our in-house selection of stylish frames makes it easy for members to take care of both their eyewear and health needs in one trip. They can visit Vision Essentials after seeing their dermatologist or visiting the lab – all under one roof. And whether their style is fashion-forward, sporty, or retro, we have just the right prescription.

Included in plan:

- Routine eye exams for children and adults.
- Ophthalmology services to treat eye diseases.
- Eyewear: Selected frames/lenses for children aged 19 and under at no charge. Discount off retail for adults: $90 frames/lenses; $25 contact lenses.

Example of your costs for care

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

Plan name	Office visit	X-ray	Most generic drugs (Tier 1)
KP DC Gold 0 Ded/100 RxDed/Vision (no deductible)	$20 (waived for children under 5)	$65	$15†
KP DC Silver Virtual Forward 4000 Ded ($4,000 deductible)	Virtual care no charge; first visit in person no charge, and additional visits in person $55 after deductible***	30% after deductible	$10†
KP DC Standard Bronze 6350 Ded/HSA/Vision ($6,350 deductible)	20% after deductible	20% after deductible	20% after deductible

You may qualify for federal or state financial assistance

The federal or state government may provide financial assistance for many people, depending on their income.

- Financial assistance is available for premiums and out-of-pocket expenses.
- Assistance is available based on income and family size.

You may be eligible for federal or state financial assistance to help you pay for care or coverage. Visit **buykp.org** for details.

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

***Virtual Forward offers virtual care at no charge; includes unlimited access to chat with a nurse, e-visits, email, and phone and video visits. First in-person visit at no charge before you reach your deductible, including primary care visits and outpatient mental health care visits.

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

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

Benefit highlights	KP DC Silver 3500 Ded/1200 RxDed/Vision
Plan type	**Deductible**
Annual medical deductible (individual/family)	$3,500/$7,000
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400
Benefits	
Virtual care	
Chat, email, e-visit, phone and video visit	No charge
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	$60
Most X-rays	$70
Most lab tests	$40
MRI, CT, PET	30% after deductible
Outpatient surgery	30% after deductible
Mental health visit	$30 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	30% after deductible
Emergency and urgent care	
Emergency department visit	30% after deductible
Urgent care visit	$60
Prescription drugs (up to a 30-day supply)	
Most generic drugs (Tier 1)	$20†
Most preferred brand name drugs (Tier 2)	$60 after $1,200 pharmacy deductible per member†
Non-preferred drugs (Tier 3)	30% after $1,200 pharmacy deductible per member
Specialty drugs (Tier 4)	30% after $1,200 pharmacy deductible per member up to $150 maximum per 30 day prescription
Whole health	
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org/Soca** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.

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

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 $3,500 for yourself or $7,000 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 $9,200 for yourself and no more than $18,400 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no additional charge

Most preventive care services—including routine physical exams and mammograms—are covered at no additional 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 (waived for children under 5)—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 30% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the rest 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 start paying a $60 copay for urgent care visits, whether or not you've met your deductible.

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

Benefit highlights	KP DC Essential Bronze 7500 Ded/1000 RxDed	KP DC Bronze 6500 Ded/Vision	KP DC Bronze 6350 Ded/HSA/Vision
Plan type	**HSA-qualified**	**HSA-qualified**	**HSA-qualified**
Annual medical deductible (individual/family)	$7,500/$15,000	$6,500/$13,000	$6,350/$12,700
Annual out-of-pocket maximum (individual/family)	$10,150/$20,300	$9,200/$18,400	$7,300/$14,600
Benefits			
Virtual care			
Chat, email, e-visit, phone and video visit	No charge	No charge	Chat, email, e-visit, phone and video visit: No charge after deductible
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$45	$65 (waived for children under 5)	20% after deductible
Specialty care office visit	$105	$85 after deductible	20% after deductible
Most X-rays	$80 after deductible	50% after deductible	20% after deductible
Most lab tests	$55 after deductible	50% after deductible	20% after deductible
MRI, CT, PET	$500 after deductible	50% after deductible	20% after deductible
Outpatient surgery	40% after deductible	50% after deductible	20% after deductible
Mental health visit	$45 (individual therapy)	$65 (individual therapy)	20% after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	50% after deductible	20% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	50% after deductible	20% after deductible
Emergency and urgent care			
Emergency department visit	40% after deductible	50% after deductible	20% after deductible
Urgent care visit	$100	$85 after deductible	20% after deductible
Prescription drugs (up to a 30-day supply)			
Most generic drugs (Tier 1)	$25†	$40†	20% after deductible
Most preferred brand name drugs (Tier 2)	$75 after $1,000 pharmacy deductible per member†	50% after deductible	20% after deductible
Non-preferred drugs (Tier 3)	$100 after $1,000 pharmacy deductible per member†	50% after deductible	20% after deductible
Specialty drugs (Tier 4)	$150 after $1,000 pharmacy deductible per member per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription	20% after deductible up to $150 maximum per 30-day prescription
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.		

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

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

Benefit highlights	KP DC Essential Silver 4850 Ded/350 RxDed	KP DC Silver Virtual Forward 4000 Ded	KP DC Silver 3500 Ded/1200 RxDed/Vision	KP DC Gold Virtual Forward 2000 Ded
Plan type	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Annual medical deductible (individual/family)	$4,850/$9,700	$4,000/$8,000	$3,500/$7,000	$2,000/$4,000
Annual out-of-pocket maximum (individual/family)	$9,150/$18,300	$8,000/$16,000	$9,200/$18,400	$6,200/$12,400
Benefits				
Virtual care				
Chat, email, e-visit, phone and video visit	No charge	No charge	No charge	No charge
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	$40	Virtual care no charge; first visit in person no charge, and additional visits in person $55 after deductible***	$30 (waived for children under 5)	Virtual care no charge; first visit in person no charge, and additional visits in person $50 after deductible***
Specialty care office visit	$80	$75 after deductible	$60	$70 after deductible
Most X-rays	$80	30% after deductible	$70	$50 after deductible
Most lab tests	$60	$75 after deductible	$40	$50 after deductible
MRI, CT, PET	$400	30% after deductible	30% after deductible	$150 after deductible
Outpatient surgery	20% after deductible	30% after deductible	30% after deductible	$200 after deductible
Mental health visit	$40 (individual therapy)	Virtual care no charge; first visit in person no charge, and additional visits in person $55 after deductible***	$30 (individual therapy)	Virtual care no charge; first visit in person no charge, and additional visits in person $50 after deductible***
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	30% after deductible	30% after deductible	$300 per day up to 3 days after deductible*
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	30% after deductible	30% after deductible	$300 per day up to 3 days after deductible*
Emergency and urgent care				
Emergency department visit	$400 after deductible (copay waived if admitted)	30% after deductible	30% after deductible	$200 after deductible
Urgent care visit	$90	$75 after deductible	$60	$70 after deductible
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$20†	$10†	$20†	$5†
Most preferred brand name drugs (Tier 2)	$50 after $350 pharmacy deductible per member†	$50 after deductible†	$60 after $1,200 pharmacy deductible per member†	$50 after deductible†
Non-preferred drugs (Tier 3)	$70 after $350 pharmacy deductible per member†	50% after deductible	30% after $1,200 pharmacy deductible per member	50% after deductible
Specialty drugs (Tier 4)	$150 after $350 pharmacy deductible per member per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription	30% after $1,200 pharmacy deductible per member up to $150 maximum per 30-day prescription	50% after deductible up to $150 maximum per 30-day prescription
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.			

*After day maximum is met, there is no charge for covered services related to this admission.

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

***Virtual Forward offers virtual care at no charge; includes unlimited access to chat with a nurse, e-visits, email, phone and video visits. First in-person visit at no charge before you reach your deductible, including primary care visits and outpatient mental health care visits.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

Benefit highlights	KP DC Gold 1800 Ded/HSA/Vision	KP DC Gold 1000 Ded/200 RxDed/Vision	KP DC Essential Gold 500 Ded/Vision	KP DC Gold 0 Ded/100 RxDed/Vision
Plan type	**HSA-qualified**	**Deductible**	**Deductible**	**Copayment**
Annual medical deductible (individual/family)	$1,800 (Self only) $3,600 (Individual in Family) $3,600 (Family)**	$1,000/$2,000	$500/$1,000	None/None
Annual out-of-pocket maximum (individual/family)	$5,000/$10,000	$7,800/$15,600	$6,950/$13,900	$7,800/$15,600
Benefits				
Virtual care				
Chat, email, e-visit, phone and video visit	No charge after deductible	No charge	No charge	No charge
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	$25 after deductible (copay waived for children under 5)	$20 (waived for children under 5)	$25	$20 (waived for children under 5)
Specialty care office visit	$50 after deductible	$40	$50	$40
Most X-rays	$65 after deductible	$70	$50	$65
Most lab tests	$30 after deductible	$40	$30	$30
MRI, CT, PET	25% after deductible	$500	$250	$500
Outpatient surgery	25% after deductible	35% after deductible	$500	35% coinsurance
Mental health visit	$25 after deductible (individual therapy)	$20 (individual therapy)	$25 (individual therapy)	$20 (individual therapy)
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% coinsurance
Maternity				
Routine prenatal care visit, first postpartum visit	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% coinsurance
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)
Urgent care visit	$50 after deductible	$40	$60	$40
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$15 after deductible†	$10†	$15†	$15†
Most preferred brand name drugs (Tier 2)	$50 after deductible†	$55†	$50†	$55†
Non-preferred drugs (Tier 3)	25% after deductible	35% after $200 pharmacy deductible per member	$70†	35% after $100 pharmacy deductible per member
Specialty drugs (Tier 4)	25% after deductible up to $150 maximum per 30-day prescription	35% after $200 pharmacy deductible per member up to $150 maximum per 30-day prescription	$150 per 30-day prescription	35% after $100 pharmacy deductible per member up to $150 maximum per 30-day prescription
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.			

*After day maximum is met, there is no charge for covered services related to this admission.

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

**For the KP DC Gold 1800 Ded/HSA/Vision plan, in a subscriber only plan, the individual deductible is $1,800. In a family version of the KP DC Gold 1800 Ded/ HSA/Vision plan, there is no individual member deductible of $1,800. Instead, there is only a family deductible of $3,600, which can be met by one or more family members. Once the combined contribution of all covered family members has reached the applicable deductible of $3,600, which 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.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on dchealthlink.com.

Benefit highlights	KP DC Gold Plus 0 Ded/100 RxDed/Vision	KP DC Essential Platinum 0 Ded/Vision	KP DC Catastrophic‡ 10600 Ded/Vision
Plan type	**Copayment**	**Copayment**	**HSA-qualified**
Annual medical deductible (individual/family)	None/None	None/None	$10,600/$21,200
Annual out-of-pocket maximum (individual/family)	$7,800/$15,600	$2,100/$4,200	$10,600/$21,200
Benefits			
Virtual care			
Chat, email, e-visit, phone and video visit	No charge‡‡‡	No charge	No charge after deductible
Preventive care			
Routine physical exam, mammograms, etc.	No charge‡‡‡	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$20 (waived for children under 5)‡‡‡	$20	First 3 office visits no charge.‡‡ Additional visits no charge after deductible.
Specialty care office visit	$40†††	$40	No charge after deductible
Most X-rays	$65†††	$40	No charge after deductible
Most lab tests	$30†††	$20	No charge after deductible
MRI, CT, PET	$500	$150	No charge after deductible
Outpatient surgery	35% coinsurance	$200	No charge after deductible
Mental health visit	$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	35% coinsurance	$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
Delivery and inpatient well-baby care	35% coinsurance	$250 per day up to 5 days*	No charge after deductible
Emergency and urgent care			
Emergency department visit	$500 (waived if admitted)	$150 (waived if admitted)	No charge after deductible
Urgent care visit	$40†††	$40	No charge after deductible
Prescription drugs (up to a 30-day supply)			
Most generic drugs (Tier 1)	$15†,†††	$5†	No charge after deductible
Most preferred brand name drugs (Tier 2)	$55†,†††	$15†	No charge after deductible
Non-preferred drugs (Tier 3)	35% after $100 pharmacy deductible per member†††	$25†	No charge after deductible
Specialty drugs (Tier 4)	35% after $100 pharmacy deductible per member up to $150 maximum per 30-day prescription†††	$100 per 30-day prescription	No charge after deductible
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.		

*After day maximum is met, there is no charge for covered services related to this 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 District of Columbia demonstrating hardship or lack of affordable coverage, may purchase a KP DC Catastrophic plan.

‡‡The KP DC Catastrophic plan includes 3 office visits at no charge before your deductible. Office visits include primary or outpatient mental health office visit.

†††With KP Plus, you're covered for up to 10 out-of-network outpatient medical visits per year, including physician office visits, lab, radiology and urgent care (inside service area), as well as up to 5 out-of-network pharmacy refills. Out-of-network payments do not accrue toward in-plan deductibles or out-of-pocket maximum.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

Cost Share Reduction (CSR) Plans

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

Benefit highlights	KP DC Silver Virtual Forward 2500 Ded/CSR	KP DC Silver Virtual Forward 750 Ded/CSR	KP DC Silver Virtual Forward 0 Ded/CSR	KP DC Essential Silver 4000 Ded/350 RxDed/CSR	KP DC Essential Silver 150 Ded/CSR
Plan type	**Deductible**	**Deductible**	**Copayment**	**Deductible**	**Deductible**
Annual medical deductible (individual/family)	$2,500/$5,000	$750/$1,500	None/None	$4,000/$8,000	$150/$300
Annual out-of-pocket maximum (individual/family)	$7,500/$15,000	$2,500/$5,000	$1,100/$2,200	$7,500/$15,000	$3,350/$6,700
Benefits					
Virtual care					
Chat, email, e-visit, phone and video visit	No charge	No charge	No charge	No charge	No charge
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	Virtual care no charge; first visit in person no charge, and additional visits in person $45 after deductible***	Virtual care no charge; first visit in person no charge, and additional visits in person $35 after deductible***	Virtual care no charge; first visit in person no charge, and additional visits in person $15***	$40	$25
Specialty care office visit	$65 after deductible	$55 after deductible	$40	$75	$40
Most X-rays	20% after deductible	10% after deductible	5%	$80	$70
Most lab tests	$65 after deductible	$55 after deductible	$40	$60	$35
MRI, CT, PET	20% after deductible	10% after deductible	5%	$400	$150
Outpatient surgery	20% after deductible	10% after deductible	5%	20% after deductible	20% after deductible
Mental health visit	Virtual care no charge; first visit in person no charge, and additional visits in person $45 after deductible***	Virtual care no charge; first visit in person no charge, and additional visits in person $35 after deductible***	Virtual care no charge; first visit in person no charge, and additional visits in person $15***	$40 (individual therapy)	$25 (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%	20% after deductible	20% after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5%	20% after deductible	20% after deductible
Emergency and urgent care					
Emergency department visit	20% after deductible	10% after deductible	5%	$400 after deductible (copay waived if admitted)	$250 after deductible (copay waived if admitted)
Urgent care visit	$65 after deductible	$55 after deductible	$40	$75	$40
Prescription drugs (up to a 30-day supply)					
Most generic drugs (Tier 1)	$10†	$5†	$3†	$20†	$15†
Most preferred brand name drugs (Tier 2)	$50 after deductible†	$30 after deductible†	$20†	$50 after $350 pharmacy deductible per member†	$50†
Non-preferred drugs (Tier 3)	50% after deductible	30% after deductible	20%	$70 after $350 pharmacy deductible per member†	$70†
Specialty drugs (Tier 4)	50% after deductible up to $150 maximum per 30-day prescription	30% after deductible up to $150 maximum per 30 -day prescription	20% after deductible up to $150 maximum per 30 -day prescription	$150 after $350 pharmacy deductible per member per 30-day prescription	$150 per 30-day prescription
Whole health					
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.				

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

***Virtual Forward offers virtual care at no charge; includes unlimited access to chat with a nurse, e-visits, email, phone and video visits. First in-person visit at no charge before you reach your deductible, including primary care visits and outpatient mental health care visits.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

Cost Share Reduction (CSR) Plans

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

Benefit highlights	KP DC Essential Silver 0 Ded/CSR	KP DC Silver 3100 Ded/1100 RxDed/CSR/ Vision	KP DC Silver 0 Ded/30 RxDed/CSR/Vision	KP DC Silver 0 Ded/CSR/Vision
Plan type	**Copayment**	**Deductible**	**Copayment**	**Copayment**
Annual medical deductible (individual/family)	None/None	$3,100/$6,200	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$2,500/$5,000	$7,600/$15,200	$3,350/$6,700	$2,400/$4,800
Benefits				
Virtual care				
Chat, email, e-visit, phone and video visit	No charge	No charge	No charge	No charge
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	$30 (waived for children under 5)	$10 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$10	$60	$40	$15
Most X-rays	$5	$70	$60	$20
Most lab tests	$5	$40	$40	$5
MRI, CT, PET	$50	30% after deductible	30% coinsurance	10% coinsurance
Outpatient surgery	15% coinsurance	30% after deductible	30% coinsurance	10% coinsurance
Mental health visit	$5	$30 (individual therapy)	$10 (individual therapy)	$5 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	15% coinsurance	30% after deductible	30% coinsurance	10% coinsurance
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	15% coinsurance	30% after deductible	30% coinsurance	10% coinsurance
Emergency and urgent care				
Emergency department visit	$250 (waived if admitted)	30% after deductible	30% coinsurance	10% coinsurance
Urgent care visit	$10	$60	$40	$15
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$5†	$20†	$10†	$5†
Most preferred brand name drugs (Tier 2)	$10†	$60 after $1,100 pharmacy deductible per member†	$60†	$10†
Non-preferred drugs (Tier 3)	$35†	30% after $1,100 pharmacy deductible per member	30% after $30 pharmacy deductible per member	10% coinsurance
Specialty drugs (Tier 4)	$100 per 30-day prescription	30% after $1,100 pharmacy deductible per member up to $150 maximum per 30-day prescription	30% after $30 pharmacy deductible per member up to $150 maximum per 30-day prescription	10% up to $150 maximum per 30-day prescription
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses and contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to improve your overall well-being. Visit **kp.org/selfcare** for more details.			

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

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. 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 **1-800-777-7902** (TTY **711**), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

Find your rate

Apply on **buykp.org** to have your rate calculated automatically.

How is your rate determined?

Your rate is based on:

- The plan you choose
- Where you live, based on your county and ZIP code
- Your age on your plan start date (effective date)
- If you qualify for federal financial assistance. Visit **buykp.org** or call us at **1-800-494-5314** (TTY **711**) 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.

Family members include:

- 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 need to pay for the 3 oldest. The other children under 21 will be covered at no charge.

Please check that your ZIP code is listed below. If it isn't, call us at **1-800-494-5314** (TTY **711**) for information on other rate areas.

ZIP codes for Washington, D.C.			
20001–13	20242–33	20330	20463
20015–20	20245	20340	20468–70
20022	20247–42	20350	20472
20024	20244–45	20355	20500–11
20026–27	20250–52	20370	20515
20029–30	20254	20372–76	20520–31
20032–33	20260–62	20380	20533–44
20035–45	20265–66	20388–95	20546–49
20047	20268	20398	20551–55
20049–50	20270	20401–29	20557
20052–53	20277	20431	20559–60
20055–71	20289	20433–37	20565–66
20073–78	20299	20439–42	20570–73
20080–82	20301	20444	20575–81
20090–91	20303	20447	20585–86
20201–04	20306	20451	20590–91
20206–08	20310	20453	20593–94
20210–24	20314	20456	20597
20226–30	20317–19	20460	20599

Benefits, Exclusions, and Limitations

Medical Exclusions

This provision provides information on what services we will not pay for regardless of whether or not the service is medically necessary.

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.

For example, if you have a non-covered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication, such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

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.

6. **Durable Medical Equipment**, except for equipment that we would specifically cover.

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:** 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.

We will consult our 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.

10. Infertility Services:

a. Except for artificial insemination or in vitro fertilization, services for 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, after an embryo transfer, to a person not covered under any health plans in connection with a surrogate/ gestational carrier pregnancy (including, but not limited to, the bearing of a child by another person for an infertile couple).

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. **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.

13. **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 are prior authorized in accord with our travel and lodging guidelines.

14. **Worker's Compensation or Employer Liability:** Any illness or injury related to employment or self-employment including any illness or injury that arises out of, or in the course of, any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the Services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law, or a similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Medical Limitations

We will make our best efforts to provide or arrange for your health care services in the event of unusual circumstances 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 center; and/or

7. Complete or partial destruction of facilities.

A riot is a public disturbance involving an assemblage of five (5) or more persons which, by tumultuous and violent conduct or the threat thereof, creates grave danger of damage or injury to property or persons. An exclusion or limitation for riot shall apply only when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot.

In the event that we are unable to provide services, we, 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. If you still refuse to accept the recommended services, we and plan providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

Pharmacy Exclusions

We do not cover:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a plan provider and are listed in our Formulary;

2. Drugs for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits;

3. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Formulary;

4. Drugs obtained from a non-plan pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered services are rendered or associated with a covered authorized referral outside the service area;

5. Take home drugs received from a hospital, skilled nursing facility, or other similar facility;

6. Drugs that are not listed in our Formulary;

7. Drugs that are considered to be experimental or investigational;

8. Drugs for which the member is not legally obligated to pay, or for which no charge is made;

9. Blood or blood products;

10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss;
11. Medical foods;
12. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a member participating in our hospice care program;
13. Replacement prescriptions necessitated by theft or loss;
14. Prescribed drugs and accessories that are necessary for services we do not cover;
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from our standard packaging for prescription drugs;
16. Alternative formulations or delivery methods that are:
    a. Different from our standard formulation or delivery method for prescription drugs; and
    b. Deemed not medically necessary.
17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies;
18. Drugs and devices that are provided during a covered stay in a hospital or skilled nursing facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug;
19. Bandages or dressings;
20. Diabetic equipment and supplies;
21. Growth hormone therapy for treatment of adults age 18 or older, except when prescribed by a plan physician, pursuant to clinical guidelines for adults;
22. Immunizations and vaccinations solely for the purpose of travel;
23. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee;
24. Drugs for weight management;
25. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction;

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Formulary. If you would like information about whether a particular drug is included in our Formulary, please visit us online at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en.pdf

You may also contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at **1-800-777-7902** or **711** (TTY).

Pharmacy Limitations

For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a plan pharmacy unless the criteria for coverage of non-preferred drugs has been met.

In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with our emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable cost share per prescription will apply. However, a member may file a claim for the difference between the cost share for a full prescription and the pro-rata cost share for the actual amount received.

Except for maintenance medications, members are limited to a thirty (30)-day supply for drugs other than contraceptive drugs and will be charged the applicable cost share based on:

a. The prescribed dosage;

b. Standard manufacturers package size; and

c. Specified dispensing limits.

For maintenance medications, members may obtain up to a ninety (90)-day supply in a single prescription, when authorized by the prescribing plan provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

a. The prescribed dosage;

b. Standard manufacturers package size; and

c. Specified dispensing limits.

Dental Exclusions

The following exclusions apply to covered dental services for children under age nineteen (19) years:

1. Any procedures not listed on this plan
2. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.

3. Dental procedures or services performed solely for cosmetic purposes or that is not dentally necessary and/or medically necessary; unless the member has purchased the additional cosmetic Ortho Plus Plan and services are within the benefit guidelines listed in the cosmetic Ortho Plus Plan.

4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving you or your dependent's dental health, as determined by the plan based on generally accepted dental standards of care.

5. For elective procedures, including prophylactic extraction of third molars.

6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged.

7. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

8. Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as covered service.

9. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.

10. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.

11. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits.

12. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.

13. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances. Invisalign services are excluded from orthodontic benefits.

15. Broken appointments unless specifically covered.

Kaiser Permanente medical facilities

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.[10]

Maryland

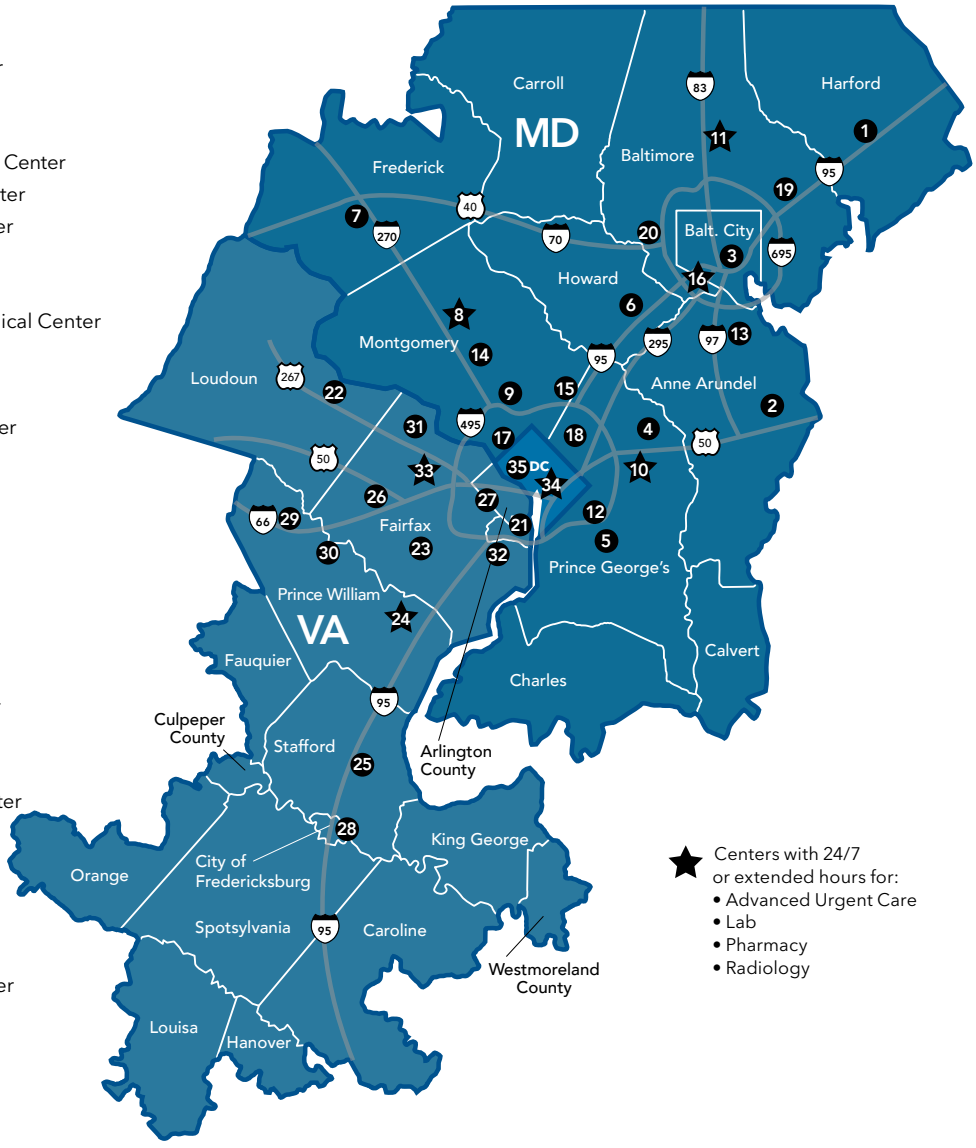
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Bowie Fairwood Medical Center
5 Camp Springs Medical Center
6 Columbia Gateway Medical Center
7 Kaiser Permanente Frederick Medical Center
8 Gaithersburg Medical Center
9 Kensington Medical Center
10 Largo Medical Center
11 Lutherville-Timonium Medical Center
12 Marlow Heights Medical Center
13 North Arundel Medical Center
14 Shady Grove Medical Center
15 Silver Spring Medical Center
16 South Baltimore County Medical Center
17 well Friendship Heights by KAISER PERMANENTE
18 West Hyattsville Medical Center
19 White Marsh Medical Center
20 Woodlawn Medical Center

Virginia

21 Alexandria Medical Center
22 Ashburn Medical Center
23 Burke Medical Center
24 Caton Hill Medical Center
25 Colonial Forge Medical Center
26 Fair Oaks Medical Center
27 Falls Church Medical Center
28 Fredericksburg Medical Center
29 Haymarket Crossroads Medical Center
30 Manassas Medical Center
31 Reston Medical Center
32 Springfield Medical Center
33 Tysons Corner Medical Center

Washington, DC

34 Kaiser Permanente Capitol Hill Medical Center
35 Northwest DC Medical Office Building



For the most current listing of available facilities and services, please visit **kp.org/facilities**.

Kaiser Permanente's service area in Fauquier County includes the following ZIP codes: 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20188, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728, and 22739.

Complete care helps you live a healthier, more fulfilled life

With Kaiser Permanente, your care is simpler, smarter, and faster – so you can spend more time doing what you love.

Ready for health care that works for you?
Visit **buykp.org** to get started.

Call **1-800-494-5314** (TTY **711**)
to talk to an enrollment specialist.

Current members with questions can call Member Services Monday through Friday, 7:30 a.m. to 9 p.m. (except holidays).

- **1-800-777-7902** (TTY **711**)

1. Kaiser Permanente internal data, 2024; Hanming Fang, PhD, et al., "Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006–2018," *JAMA Network Open*, February 24, 2022. **2.** When appropriate and available. **3.** Same-day and next-day prescription delivery services may be available for an additional fee. These services are not covered under your health plan benefits and may be limited to specific prescription drugs, pharmacies, and areas. Order cutoff times and delivery days may vary by pharmacy location. Kaiser Permanente is not responsible for delivery delays by mail carriers. Kaiser Permanente may discontinue same-day and next-day prescription delivery services at any time without notice and other restrictions may apply. Medi-Cal and Medicaid beneficiaries should ask their pharmacy for more information about prescription delivery. **4.** If you get care at a CVS MinuteClinic or Concentra urgent care, you'll be charged your standard copay or coinsurance. **5.** Some classes may require a fee. **6.** The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **7.** Kaiser Permanente 2024 HEDIS® scores. Benchmarks provided by the National Committee for Quality Assurance (NCQA) Quality Compass® and represent all lines of business. Kaiser Permanente combined region scores were provided by the Kaiser Permanente Department of Care and Service Quality. The source for data contained in this publication is Quality Compass 2024 and is used with the permission of NCQA. Quality Compass 2024 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® and HEDIS® are registered trademarks of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. **8**. American Heart Association/American Stroke Association, July 11, 2024. **9.** For a complete list of services you can use your HSA to pay for, see Publication 502, Medical and Dental Expenses, at irs.gov. **10.** Maps and facilities are subject to change.

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, 4000 Garden City Drive, Hyattsville, MD 20785, 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

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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**).

Ɓăsɔ̀ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, 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** (TTY (تلفن متنی): **711**) تماس بگیرید.

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'dęę́', 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**).

Notes

Notes

In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 4000 Garden City Drive, Hyattsville, MD 20785.

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