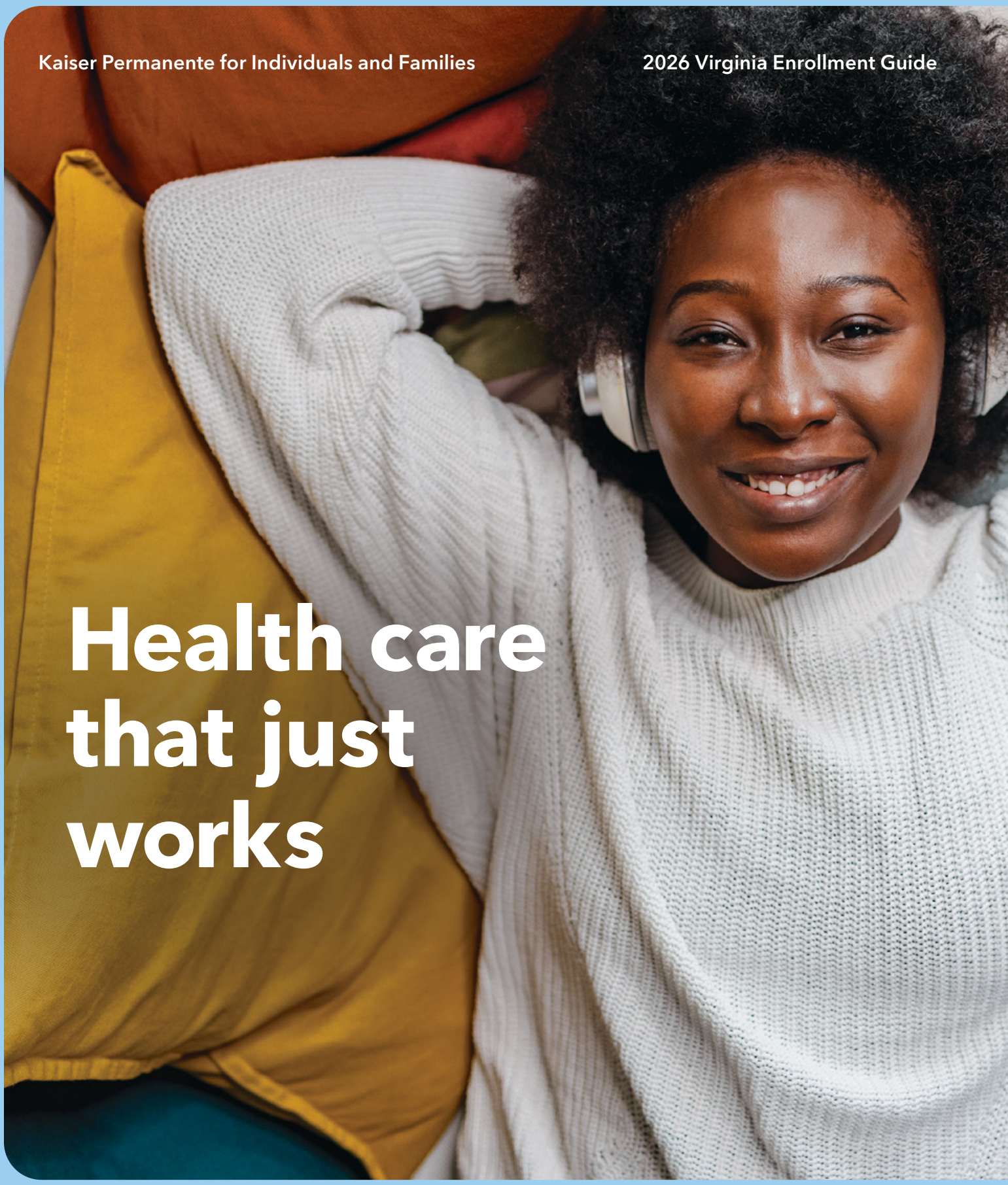
Kaiser Permanente for Individuals and Families

2026 Virginia Enrollment Guide



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 30, 2026.**
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through Virginia's Insurance Marketplace.
- For coverage that starts on **January 1, 2026,** we must receive your Application for health coverage no later than **December 31, 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.

MinuteClinics

If you need urgent care in a state without Kaiser Permanente, 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
- Affinity Musculoskeletal Program (MSK) - 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 a wide range of 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 primary care doctor at any time, so you always have a health partner you know and trust.

Recognized excellence in stroke and heart disease care[8]

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.

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. Learn more about the Mid-Atlantic Kaiser Permanente Cancer Care Institute: **mydoctor.kaiserpermanente.org/mas/specialties-and-institutes/cancer-care**.

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.

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. 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**.

Convenient and affordable dental care

Kaiser Permanente's Individual and Family dental offerings are designed for people who purchase health insurance for themselves or their families. The plans provide a range of affordable choices so that members can meet their dental needs and avoid costly procedures in the future.

Adult dental is only offered through off-exchange.

Adult dental offerings:

Kaiser Permanente Smile KPIF Dental Copay
Kaiser Permanente Smile KPIF Dental C-POS Basic
Kaiser Permanente Smile KPIF Dental C-POS High

Adding the OrthoPlus rider offers coverage for enhanced cosmetic orthodontic procedures.

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 primary care doctor knows when they're due for a comprehensive eye exam and can even schedule an appointment for glaucoma screening and other vision concerns. Of course, members can also be examined for eyeglasses or contact lens prescriptions – that's where Vision Essentials 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 stop into 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 VA Gold 0 Ded/500 RxDed/Vision (no deductible)	$20 (waived for children under 5)	$65	$10*
KP VA 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 VA Bronze 6500 Ded/Vision ($6,500 deductible)	First 3 visits $55, then 35% after deductible (copay waived for children under 5)	35% after deductible	$35*

You may qualify for federal or state financial assistance

Under health care reform, 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, 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 E KP VA Silver 2700 Ded/Vision
Plan type	**Deductible**
Annual medical deductible (individual/family)	$2,700/$5,400
Annual out-of-pocket maximum (individual/family)	$9,100/$18,200
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	$35 (waived for children under age 5)
Specialty care office visit	$55
Most X-rays	$85
Most lab tests	$60
MRI, CT, PET	40% after deductible
Outpatient surgery	40% after deductible
Mental health visit	$35 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	40% after deductible
Emergency and urgent care	
Emergency Department visit	40% after deductible
Urgent care visit	$55
Prescription drugs (up to a 30-day supply)	
Most generic drugs (Tier 1)	$20*
Most preferred brand name drugs (Tier 2)	$80*
Non-preferred drugs (Tier 3)	50% after deductible
Specialty drugs (Tier 4)	50% after deductible
Whole health	
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $2,700 for yourself or $5,400 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 $9,100 for yourself and no more than $18,200 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 $35 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 40% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd start paying a $55 copay for urgent care visits, whether or not you have met your deductible.

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

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

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

Benefit highlights	KP E KP VA Bronze 7500 Ded	KP E KP VA Standard Bronze 7500 Ded/Vision	KP E KP VA Bronze 7100 Ded/HSA/Vision	KP E KP VA Bronze 6500 Ded/Vision
Plan type	**HSA-qualified**	**HSA-qualified**	**HSA-qualified**	**HSA-qualified**
Annual medical deductible (individual/family)	$7,500/$15,000	$7,500/$15,000	$7,100/$14,200	$6,500/$13,000
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400	$10,000/$20,000	$7,100/$14,200	$9,200/$18,400
Benefits				
Virtual care				
Chat, Email, E-visit, Phone and Video visit	No charge	Same as in-person services	No charge after deductible	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% after deductible	$50	No charge after deductible	First 3 visits $55, then 35% after deductible (copay waived for children under 5)
Specialty care office visit	40% after deductible	$100	No charge after deductible	$75 after deductible
Most X-rays	40% after deductible	50% after deductible	No charge after deductible	35% after deductible
Most lab tests	40% after deductible	50% after deductible	No charge after deductible	$75
MRI, CT, PET	40% after deductible	50% after deductible	No charge after deductible	$625 after deductible
Outpatient surgery	40% after deductible	50% after deductible	No charge after deductible	35% after deductible
Mental health visit	40% after deductible	$50 (individual therapy)	No charge after deductible	$55 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	50% after deductible	No charge after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	50% after deductible	No charge after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	40% after deductible	50% after deductible	No charge after deductible	35% after deductible
Urgent care visit	40% after deductible	$75	No charge after deductible	$75 after deductible
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	40% after deductible	$25*	No charge after deductible	$35*
Most preferred brand name drugs (Tier 2)	40% after deductible	$50 after deductible*	No charge after deductible	$100 after deductible*
Non-preferred drugs (Tier 3)	50% after deductible	$100 after deductible*	No charge after deductible	50% after deductible
Specialty drugs (Tier 4)	50% after deductible	$500 after deductible*	No charge after deductible	50% after deductible
Whole health				
Healthy services	Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

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

Benefit highlights	KP E KP VA Standard Silver 6000 Ded/Vision KP VA Standard Silver 6000 Ded/Vision/Off	KP KP VA Silver Virtual Forward 5000 Ded	KP KP VA Silver 4700 Ded/HSA/Vision	KP E KP VA Silver 4500 Ded/Vision KP VA Silver 4500 Ded/Vision/Off
Plan type	**Deductible**	**Deductible**	**HSA-qualified**	**Deductible**
Annual medical deductible (individual/family)	$6,000/$12,000	$5,000/$10,000	$4,700/$9,400	$4,500/$9,000
Annual out-of-pocket maximum (individual/family)	$8,900/$17,800	$7,850/$15,700	$7,500/$15,000	$8,300/$16,600
Benefits				
Virtual care				
Chat, Email, E-visit, Phone and Video visit	Same as in-person services	No charge	No charge after deductible	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‡‡	$45 after deductible (waived for children under 5)	$40 (waived for children under 5)
Specialty care office visit	$80	$75 after deductible	$65 after deductible	$60
Most X-rays	40% after deductible	30% after deductible	$70 after deductible	$70
Most lab tests	40% after deductible	$75 after deductible	$65 after deductible	$50
MRI, CT, PET	40% after deductible	30% after deductible	35% after deductible	35% after deductible
Outpatient surgery	40% after deductible	30% after deductible	35% after deductible	35% 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‡‡	$45 after deductible (individual therapy)	$40 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	30% after deductible	35% after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	30% after deductible	35% after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	40% after deductible	30% after deductible	$500 after deductible (waived if admitted)	35% after deductible
Urgent care visit	$60	$75 after deductible	$65 after deductible	$60
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$20*	$20*	$25 after deductible*	$30*
Most preferred brand name drugs (Tier 2)	$40*	$50 after deductible*	$60 after deductible*	$60*
Non-preferred drugs (Tier 3)	$80 after deductible*	50% after deductible	50% after deductible	50% after deductible
Specialty drugs (Tier 4)	$350 after deductible*	50% after deductible	50% after deductible	50% after deductible
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

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

Benefit highlights	KP E KP VA Silver Virtual Forward 4000 Ded KP VA Silver Virtual Forward 4000 Ded/Off	KP KP VA Silver 2700 Ded/Vision	KP E KP VA Gold Virtual Forward 2500 Ded	KP KP VA Gold 2400 Ded/HSA/Vision
Plan type	**Deductible**	**Deductible**	**Deductible**	**HSA-qualified**
Annual medical deductible (individual/family)	$4,000/$8,000	$2,700/$5,400	$2,500/$5,000	$2,400 (Self only) $4,800 (Indivdual in Family)/$4,800(Family)†
Annual out-of-pocket maximum (individual/family)	$8,000/$16,000	$9,100/$18,200	$5,525/$11,050	$5,000/$10,000
Benefits				
Virtual care				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge after deductible
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	Virtual care no charge; First visit in person no charge, and additional visits in person $55 after deductible‡‡	$35 (waived for children under age 5)	Virtual care no charge; First visit in person no charge, and additional visits in person $50 after deductible‡‡	$25 after deductible (waived for children under 5)
Specialty care office visit	$75 after deductible	$55	$70 after deductible	$50 after deductible
Most X-rays	30% after deductible	$85	$50 after deductible	$60 after deductible
Most lab tests	$75 after deductible	$60	$50 after deductible	$40 after deductible
MRI, CT, PET	30% after deductible	40% after deductible	$150 after deductible	35% after deductible
Outpatient surgery	30% after deductible	40% after deductible	$270 after deductible	35% after deductible
Mental health visit	Virtual care no charge; First visit in person no charge, and additional visits in person $55 after deductible‡‡	$35 (individual therapy)	Virtual care no charge; First visit in person no charge, and additional visits in person $50 after deductible‡‡	$25 after deductible (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	40% after deductible	$300 per day up to 3 days** after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	40% after deductible	$300 per day up to 3 days** after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	30% after deductible	40% after deductible	$200 after deductible (copay waived if admitted)	$500 after deductible (waived if admitted)
Urgent care visit	$75 after deductible	$55	$70 after deductible	$50 after deductible
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$10*	$20*	$5*	$15 after deductible*
Most preferred brand name drugs (Tier 2)	$50 after deductible*	$80*	$50 after deductible*	$50 after deductible*
Non-preferred drugs (Tier 3)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Specialty drugs (Tier 4)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.			

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

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

‡‡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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

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

Benefit highlights	KP E KP VA Gold 2000 Ded/Vision	KP E KP VA Standard Gold 2000 Ded/Vision	KP KP VA Gold 1300 Ded/Vision	KP KP VA Gold 500 Ded/500 RxDed/Vision
Plan type	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Annual medical deductible (individual/family)	$2,000/$4,000	$2,000/$4,000	$1,300/$2,600	$500/$1,000
Annual out-of-pocket maximum (individual/family)	$7,300/$14,600	$8,200/$16,400	$7,800/$15,600	$9,200/$18,400
Benefits				
Virtual care				
Chat, Email, E-visit, Phone and Video visit	No charge	Same as in-person services	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 (waived for children under 5)	$30	$20 (waived for children under 5)	$20 (waived for children under 5)
Specialty care office visit	$60	$60	$50	$50
Most X-rays	30% after deductible	25% after deductible	$65	$65
Most lab tests	30% after deductible	25% after deductible	$30	$30
MRI, CT, PET	30% after deductible	25% after deductible	35% after deductible	$350 after deductible
Outpatient surgery	30% after deductible	25% after deductible	35% after deductible	35% after deductible
Mental health visit	$25 (individual therapy)	$30 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	25% after deductible	35% after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	25% after deductible	35% after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	30% after deductible	25% after deductible	35% after deductible	$750 after deductible (waived if admitted)
Urgent care visit	$60	$45	$50	$50
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$15*	$15*	$10*	$15*
Most preferred brand name drugs (Tier 2)	$60*	$30*	$55 after deductible*	$55*
Non-preferred drugs (Tier 3)	50% after deductible	$60*	45% after deductible	45% after $500 pharmacy deductible per member
Specialty drugs (Tier 4)	50% after deductible	$250*	50% after deductible	50% after $500 pharmacy deductible per member
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

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

Benefit highlights	KP E KP VA Gold 0 Ded/500 RxDed/Vision	KP KP VA Platinum 0 Ded/Vision	KP E KP VA Standard Platinum 0 Ded/Vision	KP E KP VA Catastrophic 10600 Ded/Vision††
Plan type	**Copayment**	**Copayment**	**Copayment**	**HSA-qualified**
Annual medical deductible (individual/family)	None/None	None/None	None/None	$10,600/$21,200
Annual out-of-pocket maximum (individual/family)	$9,200/$18,400	$4,500/$9,000	$5,200/$10,400	$10,600/$21,200
Benefits				
Virtual care				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	Same as in-person services	No charge after deductible
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	$20 (waived for children under 5)	$20 (waived for children under 5)	$10	First 3 office visits no charge.*** Additional visits no charge after deductible.
Specialty care office visit	$40	$40	$20	No charge after deductible
Most X-rays	$65	$60	$30	No charge after deductible
Most lab tests	$30	$40	$30	No charge after deductible
MRI, CT, PET	$500	15%	$100	No charge after deductible
Outpatient surgery	35%	15%	$300	No charge after deductible
Mental health visit	$20 (individual therapy)	$20 (individual therapy)	$10 (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%	15%	$350	No charge after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35%	15%	$350	No charge after deductible
Emergency and urgent care				
Emergency Department visit	$500 (waived if admitted)	$500 (waived if admitted)	$100	No charge after deductible
Urgent care visit	$40	$40	$15	No charge after deductible
Prescription drugs (up to a 30-day supply)				
Most generic drugs (Tier 1)	$10*	$10*	$5*	No charge after deductible
Most preferred brand name drugs (Tier 2)	$55*	$40*	$10*	No charge after deductible
Non-preferred drugs (Tier 3)	45% after $500 pharmacy deductible per member	$100*	$50*	No charge after deductible
Specialty drugs (Tier 4)	50% after $500 pharmacy deductible per member	$350*	$150*	No charge after deductible
Whole health				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.			

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

***The KP VA Catastrophic plan includes three office visits at no charge before your deductible applies. Office visits include primary or outpatient mental health office visits.

††Only applicants under age 30, or applicants age 30 and older who provide a certificate from the health benefit exchange in Virginia demonstrating hardship or lack of affordable coverage, may purchase a KP VA Catastrophic plan.

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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

E Offered through the health benefit exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through HealthCare.gov.

Benefit highlights	E KP VA Standard Silver 3000 Ded/CSR/Vision	E KP VA Standard Silver 700 Ded/CSR/Vision	E KP VA Standard Silver 0 Ded/CSR/Vision
Plan type	**Deductible**	**Deductible**	**Deductible**
Annual medical deductible (individual/family)	$3,000/$6,000	$700/$1,400	None/None
Annual out-of-pocket maximum (individual/family)	$7,400/$14,800	$3,300/$6,600	$2,200/$4,400
Benefits			
Virtual care			
Chat, Email, E-visit, Phone and Video visit	Same as in-person services	Same as in-person services	Same as in-person services
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$40	$20	No charge
Specialty care office visit	$80	$40	$10
Most X-rays	40% after deductible	30% after deductible	25%
Most lab tests	40% after deductible	30% after deductible	25%
MRI, CT, PET	40% after deductible	30% after deductible	25%
Outpatient surgery	40% after deductible	30% after deductible	25%
Mental health visit	$40 (individual therapy)	$20 (individual therapy)	No charge
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	30% after deductible	25%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	30% after deductible	25%
Emergency and urgent care			
Emergency Department visit	40% after deductible	30% after deductible	25%
Urgent care visit	$60	$30	$5
Prescription drugs (up to a 30-day supply)			
Most generic drugs (Tier 1)	$20*	$10*	No charge
Most preferred brand name drugs (Tier 2)	$40*	$20*	$15*
Non-preferred drugs (Tier 3)	$80 after deductible*	$60 after deductible*	$50*
Specialty drugs (Tier 4)	$350 after deductible*	$250 after deductible*	$150*
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

E Offered through the health benefit exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through HealthCare.gov.

Benefit highlights	E KP VA Silver 3000 Ded/CSR/Vision	E KP VA Silver 0 Ded/CSR-B/Vision	E KP VA Silver 0 Ded/CSR-A/Vision
Plan type	**Deductible**	**Copayment**	**Copayment**
Annual medical deductible (individual/family)	$3,000/$6,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700	$3,350/$6,700	$2,200/$4,400
Benefits			
Virtual care			
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services			
Primary care office visit	$35 (waived for children under age 5)	$15 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$55	$40	$15
Most X-rays	$55	$40	$15
Most lab tests	$40	$40	$5
MRI, CT, PET	35% after deductible	35%	15%
Outpatient surgery	35% after deductible	35%	15%
Mental health visit	$35 (individual therapy)	$15 (individual therapy)	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	35%	15%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	35%	15%
Emergency and urgent care			
Emergency Department visit	35% after deductible	35%	15%
Urgent care visit	$55	$40	$15
Prescription drugs (up to a 30-day supply)			
Most generic drugs (Tier 1)	$25*	$15*	$5*
Most preferred brand name drugs (Tier 2)	$60*	$60*	$10*
Non-preferred drugs (Tier 3)	40% after deductible	40%	40%
Specialty drugs (Tier 4)	50% after deductible	50%	50%
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

E Offered through the health benefit exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through HealthCare.gov.

Benefit highlights	E KP VA Silver Virtual Forward 2500 Ded/CSR	E KP VA Silver Virtual Forward 500 Ded/CSR	E KP VA Silver Virtual Forward 0 Ded/CSR
Plan type	**Deductible**	**Deductible**	**Copayment**
Annual medical deductible (individual/family)	$2,500/$5,000	$500/$1,000	None/None
Annual out-of-pocket maximum (individual/family)	$7,800/$15,600	$3,000/$6,000	$1,200/$2,400
Benefits			
Virtual care			
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge
Preventive care			
Routine physical exam, mammograms, etc.	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‡‡
Specialty care office visit	$65 after deductible	$55 after deductible	$40
Most X-rays	20% after deductible	10% after deductible	5%
Most lab tests	$65 after deductible	$55 after deductible	$40
MRI, CT, PET	20% after deductible	10% after deductible	5%
Outpatient surgery	20% after deductible	10% after deductible	5%
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‡‡
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	10% after deductible	5%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5%
Emergency and urgent care			
Emergency Department visit	20% after deductible	10% after deductible	5%
Urgent care visit	$65 after deductible	$55 after deductible	$40
Prescription drugs (up to a 30-day supply)			
Most generic drugs (Tier 1)	$5*	$5*	No charge
Most preferred brand name drugs (Tier 2)	$50 after deductible*	$30 after deductible*	$20*
Non-preferred drugs (Tier 3)	50% after deductible	40% after deductible	40%
Specialty drugs (Tier 4)	50% after deductible	50% after deductible	50%
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. 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. Most deductibles, 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.
- If you add an optional dental rider for family members 19 and older

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 Virginia				
20101–05	20175–78	22081–82	22225–27	22534–35
20108–13	20180–82	22095–96	22230	22538
20115	20184	22101–03	22240–46	22544–47
20116	20185	22106–09	22301–15	22551
20117–22	20186	22116	22320	22553–56
20124	20187	22118–19	22331–34	22565
20128	20188	22121–22	22350	22567
20129	20189–92	22124–25	22401–08	22580
20131–32	20194–97	22134–35	22412	22639
20134–37†	20198	22150–53	22430	22642
20138	20598	22156	22443	22643
20139	22003	22158–61	22446	22720
20140	22009	22172	22448	22728
20141–43	22015	22180–83	22451	22736
20144	22025–27	22185	22463	22739
20146–49	22030–44	22191–95	22471	22960†
20151–53	22046	22199	22481	23015
20155–56	22060	22201–07	22485	23024
20158–60	22066–67	22209–17	22508	23117†
20163–72	22079	22219	22526	23170

† Portions of ZIP code not in service area: 20135, 22960, and 23117

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.[17]

Maryland

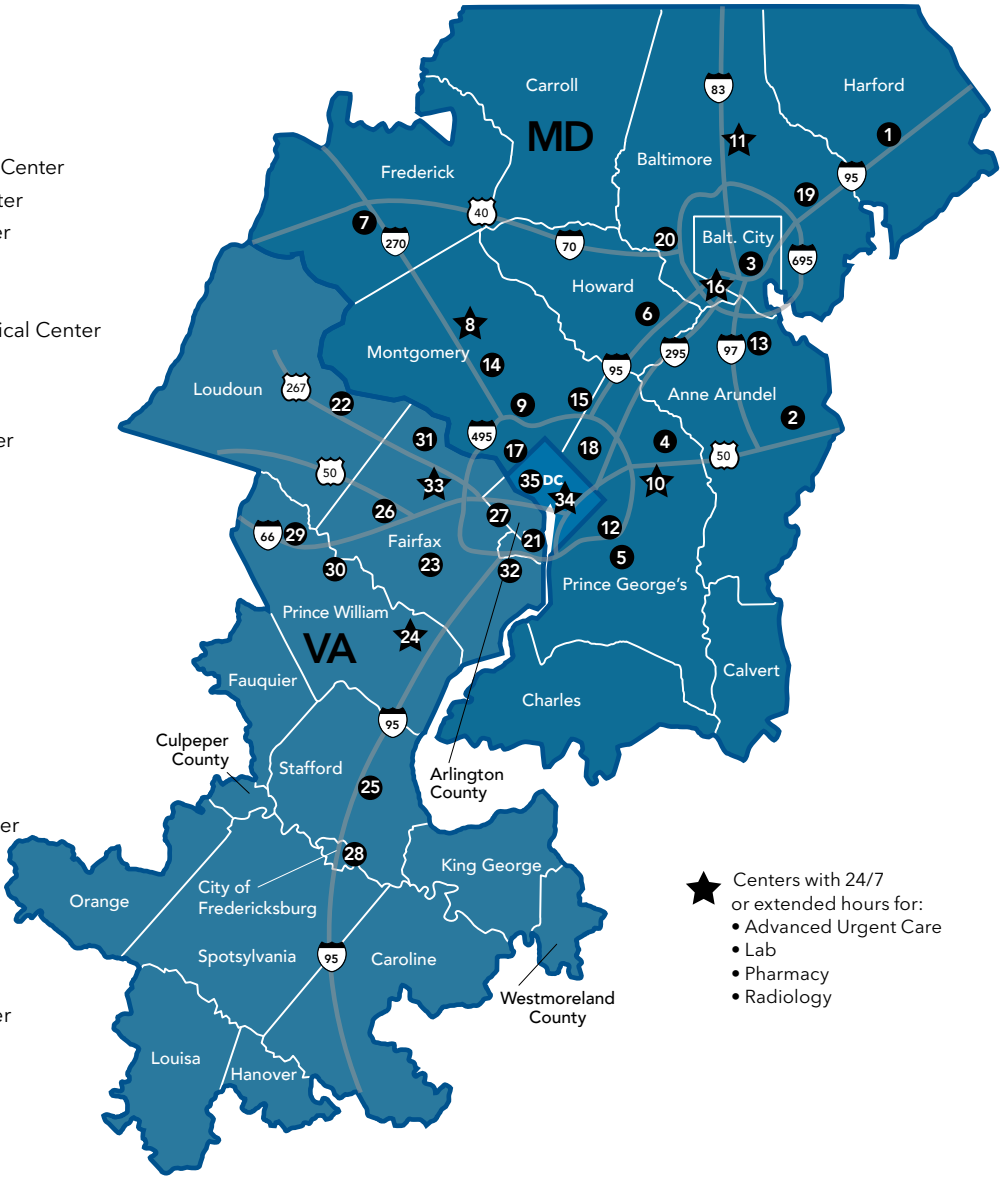
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 Bowie Fairwood Medical Center
5 Camp Springs Medical Center
6 Columbia Gateway Medical Center
7 Kaiser Permanente Frederick Medical Center
8 Gaithersburg Medical Center
9 Kensington Medical Center
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.

Important details and notices

Notice of insurance information practices – abbreviated version

Virginia

Please be advised that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter Kaiser Permanente), has not received any personal information regarding your application from any person other than the applicant. Personal information necessary to determine eligibility for coverage may be collected from the application.

Please also be assured that it is Kaiser Permanente's policy to protect the confidentiality of your private medical information to the full extent of the law.

Kaiser Permanente will not disclose any personal or privileged information about an individual that is collected or received unless the disclosure is:

- Authorized in writing by the individual; or
- Made to a medical care institution or medical professional for the purpose of:
  - Verifying insurance coverage or benefits, or
  - Informing an individual of a medical problem of which the individual may not be aware, or
  - Conducting an operations or services audit, provided that information is disclosed only as is reasonably necessary to accomplish the foregoing purposes; or
- Made to an insurance regulatory authority; or
- Made to a law enforcement or other government authority to protect Kaiser Permanente interests in preventing or prosecuting the perpetration of fraud upon it; or
- As permitted by applicable law.

You have the right to see and obtain copies of the recorded personal information pertaining to you by submitting a written request. If you ask us to correct, amend, or delete any information about you in our files and if we refuse to do so, you have the right to give us a concise statement of what you believe is the correct information and we will put your statement in our file so that anyone reviewing it will see it.

Information obtained from a report prepared by an insurance-support organization may be retained by an insurance-support organization and disclosed to other persons.

This is an abbreviated version of the notice of information collection and disclosure practices. Kaiser Permanente's complete *Notice of Insurance Information Practices* form is available to you upon request.

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 direct complications of the non-covered service.

For example, if you have a non-covered cosmetic surgery, we will 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 will 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. **Alternative Medical Services**
    a. Acupuncture
    b. Holistic medicine
    c. Homeopathic medicine
    d. Hypnosis
    e. Aroma therapy
    f. Massage and massage therapy
    g. Reiki therapy
    h. Herbal, vitamin or dietary products or therapies
    i. Naturopathy
    j. Thermography
    k. Orthomolecular therapy
    l. Contact reflex analysis
    m. Bioenergial synchronization technique (BEST)
    n. Iridology-study of the iris
    o. Auditory integration therapy (AIT)
    p. Colonic irrigation
    q. Magnetic innervation therapy
    r. Electromagnetic therapy
    s. Neurofeedback/Biofeedback.

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 determination; or
    c. On court-order or required for parole or probation.

3. **Cosmetic Services**

    Cosmetic services, including treatment, services, prescription drugs, equipment, or supplies meant to preserve, change, or improve your appearance for reasons other than for medical necessity. This exclusion does not apply to surgery or related Services to restore bodily function or correct deformity resulting from disease, trauma, or previous therapeutic process, to correct congenital or developmental anomalies, including those in newborn children, that cause functional impairment, or the Medically Necessary benefits determined according to non-discriminatory criteria

that are consistent with current medical standards. Examples of cosmetic services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.

4. **Court Ordered Testing**

   Court ordered testing or care unless medically necessary.

5. **Custodial Care**

   Custodial care means assistance with activities of daily living, such as 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. This exclusion does not apply to custodial care received while under hospice care.

6. **Dental Care**

   Dental care and dental x-rays, including dental appliances, dental implants, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome. This exclusion does not apply to medically necessary dental care.

7. **Disposable Supplies**

   Disposable supplies for home use such as bandages, gauze, tape, antiseptics, ace-type bandages.

8. **Durable Medical Equipment**,

   except for equipment that we would specifically cover.

9. **Employer or Government Responsibility**

   Financial responsibility for services that an employer or government agency is required by law to provide.

10. **Experimental or Investigational Services**

    A service or supply, including those found to be related to experimental or investigational services, regardless if received before, during, or after receipt of the experimental or investigational service or supply. A service or supply 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 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

a. 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 with our Medical Group and then use the criteria described above to decide if a particular service is experimental or investigational.

11. Family Members

Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse or domestic partner, child, brother, sister, parent, in-law, or self.

12. Health Club Memberships and Fitness Services

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even when ordered by a plan provider. This exclusion also applies to health spas.

13. Prosthetic and Orthotic Devices

Prosthetics for sports or cosmetic purposes. Services and supplies for external prosthetic and orthotic devices.

14. Routine Foot Care Services,

except when medically necessary.

15. Travel and Lodging Expenses,

except that in some situations if a plan physician refers you to a non-plan provider outside our Service Area, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines; or if travel and lodging expenses are incurred as part of transplant services.

15. Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

16. Workers' Compensation or Employer's Liability

Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, Services during a jail or prison sentence, Services you get from workers' compensation, and Services from free clinics. If workers' compensation benefits are not available to you, this exclusion does not apply. This exclusion will apply if you get the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

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 office; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide the 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.

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. Compounded preparations that do not contain at least one (1) ingredient requiring a prescription and are not listed in our formulary;
3. Take home drugs received from a hospital, skilled nursing facility or other similar facility;
4. Drugs that are considered to be experimental or investigational;
5. Drugs that can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., the same active ingredient and dosage) to a prescription drug, unless otherwise prohibited by state or federal laws governing Essential Health Benefits;
6. Drugs for which the member is not legally obligated to pay or for which no charge is made;

1. 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;
2. Drugs for the palliation and management of terminal illness unless they are provided by a licensed hospice agency to a member participating in our hospice care program;
3. Prescribed drugs and accessories that are necessary for services that we do not cover;
4. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from our standard packaging for prescription drugs;
5. Alternative formulations or delivery methods that are different from our standard formulation or delivery method for prescription drugs and deemed not medically necessary;
6. 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;
7. Bandages or dressings;
8. Diabetic equipment and supplies;
9. Immunizations and vaccinations solely for the purpose of travel;
10. 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. The determination by the Pharmacy and Therapeutics Committee is subject to appeal if the prescribing physician believes the over-the-counter therapeutically equivalent drug is inappropriate therapy for treatment of the patient's condition;
11. Drugs for weight management;
12. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
13. Drugs for the treatment of infertility.

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-formulary brand 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 and contraceptive drugs, members may obtain up to a thirty (30)-day supply and will be charged the applicable cost share based on the:

1. Prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one cost share at the initial dispensing for each thirty (30)-day supply.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

1. the prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member; and
2. the member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs.

Except for maintenance medications and contraceptive drugs, as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

For maintenance medications, members may obtain up to a ninety (90)-day supply of maintenance medications 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 the:

1. Prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

For contraceptives, members may obtain up to a twelve (12)-month supply of prescription contraceptives in a single prescription, when authorized by the prescribing plan provider or a referral physician.

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 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.

1. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged unless otherwise listed as a covered service.
2. 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.
3. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
4. 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.
5. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits.
6. 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.
7. 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.
8. 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.
9. Missed or cancelled appointments, unless specifically listed as a Covered Service.

Notes

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 and 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

---

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**).

Bă sɔ̀ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Bàsàa, 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, koji̯' 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.

KAISER PERMANENTE®