

Small Business Plan Summaries | MARYLAND | 2026



COVERAGE OPTIONS

Employees may choose from four plan categories (metal levels):

PLATINUM - Highest monthly premium - Zero/lowest deductible	GOLD - Higher monthly premium - Lower deductible	SILVER - Moderate monthly premium - Moderate deductible	BRONZE - Lowest monthly premium - Highest deductible
---	--	---	--

PORTFOLIO SNAPSHOT

← Lower cost Price spectrum Higher cost →					
	HSA-Qualified Consumer-Directed Health Plan	HMO/Deductible HMO	KP Plus/Deductible KP Plus	Added Choice 2-Tier POS	Flexible Choice 3-Tier POS ¹
Product features	- Lowest cost plans at premium level - Option for tax-advantaged savings account - IRS-regulated minimum deductible - All benefits subject to deductible	- Well-priced and quality health care with very predictable costs - Minimal costs subject to deductible - Broad range of deductibles and copays - Also available in the Select care system: more community providers than that for core Signature	- In-network: Identical to comprehensive Kaiser Permanente HMO - Coverage outside Kaiser Permanente for up to 10 outpatient visits a year (limits apply) - Up to 5 pharmacy fills a year at facilities outside Kaiser Permanente - Price advantage compared to Added Choice and Flexible Choice	- In-network: Identical to comprehensive Kaiser Permanente HMO - Out-of-network: any licensed provider in the US - No referrals needed to see a specialist in Tier 2 - Choice of provider each time care is sought - Competitive option that fits needs of all employees	- In-network Tier 1: Identical to comprehensive Kaiser Permanente HMO - In-network Tier 2: Curated national PPO network - Out-of-network: Any licensed provider in US - No referrals required for specialists in Tiers 2 and 3 - Offer side-by-side with other Kaiser Permanente plans to lower overall costs and still offer choice
May be a good fit for those who:	- Desire tax-advantaged long-term savings vehicle - Are willing to pay higher out-of-pocket costs at point of care - Are in a workforce with relatively low care needs - Are close to and/or contained within the Kaiser Permanente delivery footprint	- Value quality and the convenience of fully integrated model - Seek to balance premium cost and comprehensive coverage - Are close to and/or contained within the Kaiser Permanente delivery footprint	- Want the option to keep current primary care provider and/or care relationships while transitioning to Kaiser Permanente - Are new to integrated care, trying out options - Have some care needs outside the Kaiser Permanente service area but not for full coverage (e.g., limited workforce travel)	- Have sustained care needs outside the Kaiser Permanente service area (e.g., college students) - Sole carrier groups - Have a strong preference for choice - Have experience with two-tier products - Have larger groups with most employees within and around the Kaiser Permanente footprint	- Have a broad range of employees with divergent needs - Have senior leaders who need choice and/or employment benefit - Are new to integrated care with strong choice preference - Have employees who travel often outside the Kaiser Permanente footprint - Have large and mid-size groups with employees both within and outside the Kaiser Permanente footprint
Relative price ²	• 0.80x	• 1.00x - 1.05x	• 1.04x	• 1.24x	• 1.36x

¹Available in Maryland and Virginia only

²Compared to HMOs with similar benefits

TABLE OF CONTENTS



Maryland health plans

Platinum plan summaries.....	2
Gold plan summaries	4
Silver plan summaries	18
Bronze plan summaries.....	25
Definitions, exclusions, and limitations	29

PLATINUM PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are “non-grandfathered health plans” under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

KP Offered through Kaiser Permanente **S** Offered through Small Business Options Program (SHOP), Maryland Health Connection

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP MD Platinum 0 Ded/Vision	KP KP MD Platinum ^(ig) Plus 0 Ded/Vision		KP S KP MD Platinum ^(ia) 500 Ded/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Individual plan annual deductible (subscriber only)	None	None	Not applicable	\$500
Family plan annual deductible (individual/family)	None/None	None/None	Not applicable	\$500/\$1,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,650	\$2,650	Not applicable	\$2,700
Family plan annual out-of-pocket maximum (individual/family)	\$2,650/\$5,300	\$2,650/\$5,300	Not applicable	\$2,700/\$5,400
Network ⁽ⁱⁱⁱ⁾	KP Signature or Select S Signature only	KP Signature only	Not applicable	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit	\$10	\$10	\$30 (applies to 10-visit limit)	\$20
Specialty care office visit	\$30	\$30	\$50 (applies to 10-visit limit)	\$30
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	X-ray \$30/Lab \$10	X-ray \$30/Lab \$10	X-ray \$50/Lab \$30 (applies to 10-visit limit)	X-ray \$30/Lab \$20
MRI/CT/PET	\$100	\$100	Not covered	\$50 after deductible
Telehealth	No charge	No charge	\$30 (applies to 10-visit limit)	No charge
Outpatient facility fee	\$100	\$100	Not covered	\$50 after deductible
Mental health/chemical dependency outpatient	\$10 individual therapy \$5 group therapy	\$10 individual therapy \$5 group therapy	\$30 individual therapy \$15 group therapy (applies to 10-visit limit)	\$20 individual therapy \$10 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$200 per admission	\$200 per admission	Not covered	\$150 per admission after deductible

PLATINUM PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Platinum 0 Ded/Vision	 KP MD Platinum ^(ig) Plus 0 Ded/Vision		 KP MD Platinum ^(ia) 500 Ded/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Prescription Drugs (30-day supply)				
Rx--deductible	None	None	Not applicable	None
Rx--generic drugs (Tier 1)	\$10	\$10	\$30 (each fill/refill applies to the 5-prescription limit)	\$10
Rx--preferred brand drugs (Tier 2)	\$45	\$45	\$65 (each fill/refill applies to the 5-prescription limit)	\$45
Rx--non-preferred brand drugs (Tier 3)	\$65	\$65	\$85 (each fill/refill applies to the 5-prescription limit)	\$65
Rx--specialty drugs (Tier 4)	50% up to \$150	50% up to \$150	60% up to \$150 (each fill/refill applies to the 5-prescription limit)	50% up to \$150
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	\$30	\$30	\$30	\$30
Emergency room	\$200 (waived if admitted)	\$200 (waived if admitted)	\$200 (waived if admitted)	\$150 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	\$30	\$30	\$50 (applies to 10-visit limit)	\$30
Pediatric Dental Services				
Periodic oral evaluation	\$5	\$5	Not covered	\$5
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Topical application of fluoride	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	Not covered	\$0 (no additional cost for 1 to 4 films) ¹
Pediatric Vision Services				
Routine eye exam with optometrist	\$10	\$10	Not covered	\$20
Frames	No charge ²	No charge ²	Not covered	No charge ²
Lenses	No charge ²	No charge ²	Not covered	No charge ²
Contacts	No charge ³	No charge ³	Not covered	No charge ³
Adult Vision Services				
Routine eye exam with optometrist	\$10	\$10	Not covered	\$20
Frames	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Lenses	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Contacts	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴

For details about (ia), (ig), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

GOLD PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

KP Offered through Kaiser Permanente **S** Offered through Small Business Options Program (SHOP), Maryland Health Connection

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP MD Gold 0 Ded/Vision	KP KP MD Gold Plus^(ig) 0 Ded/Vision		KP KP MD Gold^(ia) 500 Ded/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Individual plan annual deductible (subscriber only)	\$0	\$0	Not applicable	\$500
Family plan annual deductible (individual/family)	\$0	\$0	Not applicable	\$500/\$1,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	\$9,000	\$9,000	Not applicable	\$8,500
Family plan annual out-of-pocket maximum (individual/family)	\$9,000/\$18,000	\$9,000/\$18,000	Not applicable	\$8,500/\$17,000
Network ⁽ⁱⁱⁱ⁾	KP Signature or Select S Signature only	KP Signature only	Not applicable	KP Signature or Select
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit	\$25	\$25	\$45 (applies to 10-visit limit)	\$20
Specialty care office visit	\$55	\$55	\$75 (applies to 10-visit limit)	\$50
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	\$50	\$50	\$70 (applies to 10-visit limit)	\$50
MRI/CT/PET	\$300	\$300	Not covered	\$300 after deductible
Telehealth	No charge	No charge	\$40 (applies to 10-visit limit)	No charge
Outpatient facility fee	\$250	\$250	Not covered	\$250 after deductible
Mental health/chemical dependency outpatient services	\$25 individual therapy \$12 group therapy	\$25 individual therapy \$12 group therapy	\$45 individual therapy \$22 group therapy (applies to 10-visit limit)	\$20 individual therapy \$10 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$500 per admission	\$500 per admission	Not covered	\$500 per admission after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold 0 Ded/Vision	 KP MD Gold Plus ^(ig) 0 Ded/Vision		 KP MD Gold ^(ia) 500 Ded/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Prescription Drugs (30-day supply)				
Rx–deductible	None	None	Not applicable	None
Rx–generic drugs (Tier 1)	\$15	\$15	\$35 (each fill/refill applies to the 5-prescription limit)	\$15
Rx–preferred brand drugs (Tier 2)	\$50	\$50	\$70 (each fill/refill applies to the 5-prescription limit)	\$50
Rx–non-preferred brand drugs (Tier 3)	\$70	\$70	\$90 (each fill/refill applies to the 5-prescription limit)	\$70
Rx–specialty drugs (Tier 4)	50% up to \$150	50% up to \$150	60% up to \$150 (each fill/refill applies to the 5-prescription limit)	50% up to \$150
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	\$55	\$55	\$55	\$50
Emergency room	\$500 (waived if admitted)	\$500 (waived if admitted)	\$500 (waived if admitted)	\$500 after deductible
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	\$55	\$55	\$75 (applies to 10-visit limit)	\$50
Pediatric Dental Services				
Periodic oral evaluation	\$5	\$5	Not covered	\$5
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Topical application of fluoride	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	Not covered	\$0 (no additional cost for 1 to 4 films) ¹
Pediatric Vision Services				
Routine eye exam with optometrist	\$25	\$25	Not covered	\$20
Frames	No charge ²	No charge ²	Not covered	No charge ²
Lenses	No charge ²	No charge ²	Not covered	No charge ²
Contacts	No charge ³	No charge ³	Not covered	No charge ³
Adult Vision Services				
Routine eye exam with optometrist	\$25	\$25	Not covered	\$20
Frames	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Lenses	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Contacts	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴

For details about (ia), (ig), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold^(ia) 1,000 Ded/150 RxDed/ Vision	 KP MD Gold^(ib) 1,500 Ded/200 RxDed/ Vision	 KP MD Gold Plus^(ig) 1,500 Ded/200 RxDed/Vision	
			Kaiser Permanente Providers	Out-of-Network Providers
Individual plan annual deductible (subscriber only)	\$1,000	\$1,500	\$1,500	Not applicable
Family plan annual deductible (individual/family)	\$1,000/\$2,000	\$1,500/\$3,000	\$1,500/\$3,000	Not applicable
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	100%/0%	Not applicable
Individual plan annual out-of-pocket maximum (subscriber only)	\$8,300	\$8,300	\$8,300	Not applicable
Family plan annual out-of-pocket maximum (individual/family)	\$8,300/\$16,600	\$8,300/\$16,600	\$8,300/\$16,600	Not applicable
Network ⁽ⁱⁱⁱ⁾	 Signature or Select  Signature only	 Signature or Select	 Signature only	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit	\$20	\$20	\$20	\$40 (applies to 10-visit limit)
Specialty care office visit	\$50	\$50	\$50	\$70 (applies to 10-visit limit)
Preventive care/screening/immunization	No charge	No charge	No charge	No charge (applies to 10-visit limit)
X-ray and lab diagnostic services	\$50	\$50	\$50	\$70 (applies to 10-visit limit)
MRI/CT/PET	\$300 after deductible	\$300 after deductible	\$300 after deductible	Not covered
Telehealth	No charge	No charge	No charge	\$40 (applies to 10-visit limit)
Outpatient facility fee	\$250 after deductible	\$250 after deductible	\$250 after deductible	Not covered
Mental health/chemical dependency outpatient services	\$20 individual therapy \$10 group therapy	\$20 individual therapy \$10 group therapy	\$20 individual therapy \$10 group therapy	\$40 individual therapy \$20 group therapy (applies to 10-visit limit)
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	Not covered
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$500 per admission after deductible	\$500 per admission after deductible	\$500 per admission after deductible	Not covered

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold ^(ia) 1,000 Ded/150 RxDed/ Vision	 KP MD Gold ^(ib) 1,500 Ded/200 RxDed/ Vision	 KP MD Gold Plus ^(ig) 1,500 Ded/200 RxDed/Vision	
	Kaiser Permanente Providers			Out-of-Network Providers
Prescription Drugs (30-day supply)				
Rx–deductible	\$150	\$200	\$200	Not applicable
Rx–generic drugs (Tier 1)	\$15	\$15	\$15	\$35 (each fill/refill applies to the 5-prescription limit)
Rx–preferred brand drugs (Tier 2)	\$50 after Rx deductible	\$50 after Rx deductible	\$50 after Rx deductible	\$70 (each fill/refill applies to the 5-prescription limit)
Rx–non-preferred brand drugs (Tier 3)	\$65 after Rx deductible	\$65 after Rx deductible	\$65 after Rx deductible	\$120 (each fill/refill applies to the 5-prescription limit)
Rx–specialty drugs (Tier 4)	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	60% up to \$150 (each fill/refill applies to the 5-prescription limit)
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	\$50	\$50	\$50	\$50
Emergency room	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	\$50	\$50	\$50	\$70 (applies to 10-visit limit)
Pediatric Dental Services				
Periodic oral evaluation	\$5	\$5	\$5	Not covered
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	\$0 ¹	Not covered
Topical application of fluoride	\$0 ¹	\$0 ¹	\$0 ¹	Not covered
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	Not covered
Pediatric Vision Services				
Routine eye exam with optometrist	\$20	\$20	\$20	Not covered
Frames	No charge ²	No charge ²	No charge ²	Not covered
Lenses	No charge ²	No charge ²	No charge ²	Not covered
Contacts	No charge ³	No charge ³	No charge ³	Not covered
Adult Vision Services				
Routine eye exam with optometrist	\$20	\$20	\$20	Not covered
Frames	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered
Lenses	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered
Contacts	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered

For details about (ia), (ib), (ig), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold^(ic) 1,700 Ded/HSA/Vision	 KP MD Gold Added Choice^(id) 1,000 Ded/150 RxDed	
		In-Network	Out-of-Network
Individual plan annual deductible (subscriber only)	\$1,700	\$1,000	\$2,000
Family plan annual deductible (individual/family)	N/A (individual)/\$3,400	\$1,000/\$2,000	\$2,000/\$4,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	\$5,500	\$8,300	\$16,600
Family plan annual out-of-pocket maximum (individual/family)	\$5,500/\$11,000	\$8,300/\$16,600	\$16,600/\$33,200
Network ⁽ⁱⁱⁱ⁾	 Signature or Select  Signature only	 Signature or Select	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit	No charge after deductible	\$20	\$45 after deductible
Specialty care office visit	No charge after deductible	\$50	\$55 after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible
X-ray and lab diagnostic services	No charge after deductible	\$50	\$60 after deductible
MRI/CT/PET	\$75 after deductible	\$300 after deductible	\$450 after deductible
Telehealth	No charge after deductible	No charge	Applicable cost share will apply based on type of provider
Outpatient facility fee	\$100 after deductible	\$250 after deductible	\$350 after deductible
Mental health/chemical dependency outpatient services	No charge after deductible	\$20 individual therapy \$10 group therapy	\$45 individual therapy \$30 group therapy (after deductible)
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge after deductible
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$200 per admission after deductible	\$500 per admission after deductible	\$600 per admission after deductible
Prescription Drugs (30-day supply)			
Rx-deductible	Medical deductible applies	\$150	Medical deductible applies
Rx-generic drugs (Tier 1)	\$10 after deductible	\$15	\$25 after deductible
Rx-preferred brand drugs (Tier 2)	\$45 after deductible	\$50 after Rx deductible	\$60 after deductible
Rx-non-preferred brand drugs (Tier 3)	\$65 after deductible	\$65 after Rx deductible	\$75 after deductible
Rx-specialty drugs (Tier 4)	50% up to \$150 after deductible	50% up to \$150 after Rx deductible	50% up to \$150 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold ^(ic) 1,700 Ded/HSA/Vision	 KP MD Gold Added Choice ^(id) 1,000 Ded/150 RxDed	
		In-Network	Out-of-Network
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	No charge after deductible	\$50	\$55 after deductible
Emergency room	\$350 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	No charge after deductible	\$50	\$55 after deductible
Pediatric Dental Services			
Periodic oral evaluation	\$5	\$0 ¹	20%
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	20%
Topical application of fluoride	\$0 ¹	\$0 ¹	20%
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	20%
Pediatric Vision Services			
Routine eye exam with optometrist	No charge after deductible	\$20	\$45 after deductible
Frames	No charge after deductible ²	No charge ²	20% after deductible ²
Lenses	No charge after deductible ²	No charge ²	20% after deductible ²
Contacts	No charge after deductible ³	No charge ³	20% after deductible ³
Adult Vision Services			
Routine eye exam with optometrist	No charge after deductible	\$20	\$45 after deductible
Frames	Not covered	\$125 discount off retail price ⁴	10% discount off retail price
Lenses	Not covered	\$125 discount off retail price ⁴	10% discount off retail price
Contacts	Not covered	\$125 discount off retail price ⁴	5% discount off retail price

For details about (ic), (id), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold Flexible Choice^(1e) 0 Ded/300 RxDed		
	Option 1 ¹	Option 2 ¹	Option 3 ¹
Individual plan annual deductible (subscriber only)	None	\$1,000	\$4,000
Family plan annual deductible (individual/family)	None/None	\$1,000/\$2,000	\$4,000/\$8,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$4,900	\$5,050	\$10,150
Family plan annual out-of-pocket maximum (individual/family)	\$4,900/\$9,800	\$5,050/\$10,100	\$10,150/\$20,300
Network ⁽ⁱⁱⁱ⁾	 Signature only	MultiPlan [®] and/or PHCS [™] , Cigna Healthcare SM PPO	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit	\$25	\$35	20% after deductible
Specialty care office visit	\$50	\$60	20% after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible
X-ray and lab diagnostic services	X-ray \$40/Lab \$30	X-ray \$50/Lab \$40	20% after deductible
MRI/CT/PET	\$350	\$400 after deductible	20% after deductible
Telehealth	No charge	Applicable cost share will apply based on type of provider	20% after deductible
Outpatient facility fee	\$275	\$325 after deductible	20% after deductible
Mental health/chemical dependency outpatient services	\$25 individual therapy \$12 group therapy	\$35 individual therapy \$17 group therapy	20% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	20% after deductible
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$550 per admission	\$600 per admission after deductible	20% after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold Flexible Choice^(ie) 0 Ded/300 RxDed		
	Option 1 ¹	Option 2 ¹	Option 3 ¹
Prescription Drugs (30-day supply)			
Rx–deductible	\$300	\$300	Medical deductible applies
Rx–generic drugs (Tier 1)	\$25	\$45	20% after deductible
Rx–preferred brand drugs (Tier 2)	\$50 after Rx deductible	\$80 after Rx deductible	20% after deductible
Rx–non-preferred brand drugs (Tier 3)	\$80 after Rx deductible	\$100 after Rx deductible	20% after deductible
Rx–specialty drugs (Tier 4)	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	50% up to \$150 after deductible
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	\$50	\$60	20% after deductible
Emergency room	\$500 (waived if admitted)	\$500 (waived if admitted)	\$500 (waived if admitted)
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	\$50	\$60	20% after deductible
Pediatric Dental Services			
Periodic oral evaluation	\$0 ²	Covered in plan	20%
Prophylaxis (cleaning)	\$0 ²	Covered in plan	20%
Topical application of fluoride	\$0 ²	Covered in plan	20%
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ²	Covered in plan	20%
Pediatric Vision Services			
Routine eye exam with optometrist	\$25	\$35	20% after deductible
Frames	No charge ³	Not available	40% after deductible
Lenses	No charge ³	Not available	40% after deductible
Contacts	No charge ⁴	Not available	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	\$25	\$35	20% after deductible
Frames	\$125 discount off retail ⁵	Not available	40% up to \$100 after deductible
Lenses	\$125 discount off retail ⁵	Not available	40% up to \$150 after deductible
Contacts	\$125 discount off retail ⁵	Not available	40% up to \$50 after deductible

For details about (ie) and (iii), see the Definitions section on page 29.

¹Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).

²For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

³One pair per year from a selected group of frames.

⁴Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁵Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold Flexible Choice^(ie) 1,000 Ded/200 RxDed		
	Option 1 ¹	Option 2 ¹	Option 3 ¹
Individual plan annual deductible (subscriber only)	\$1,000	\$1,500	\$4,000
Family plan annual deductible (individual/family)	\$1,000/\$2,000	\$1,500/\$3,000	\$4,000/\$8,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$5,000	\$5,150	\$10,150
Family plan annual out-of-pocket maximum (individual/family)	\$5,000/\$10,000	\$5,150/\$10,300	\$10,150/\$20,300
Network ⁽ⁱⁱⁱ⁾	 Signature only	MultiPlan [®] and/or PHCS [™] , Cigna Healthcare SM PPO	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit	\$20	\$30	20% after deductible
Specialty care office visit	\$40	\$50	20% after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible
X-ray and lab diagnostic services	X-ray \$40/Lab \$25	X-ray \$50/Lab \$35	20% after deductible
MRI/CT/PET	\$350 after deductible	\$400 after deductible	20% after deductible
Telehealth	No charge	Applicable cost shares will apply based on type of provider	20% after deductible
Outpatient facility fee	\$275 after deductible	\$325 after deductible	20% after deductible
Mental health/chemical dependency outpatient services	\$20 individual therapy \$10 group therapy	\$30 individual therapy \$15 group therapy	20% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	20% after deductible
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$550 per admission after deductible	\$600 per admission after deductible	20% after deductible
Prescription Drugs (30-day supply)			
Rx-deductible	\$200	\$250	Medical deductible applies
Rx-generic drugs (Tier 1)	\$25	\$45	20% after deductible
Rx-preferred brand drugs (Tier 2)	\$50 after Rx deductible	\$80 after Rx deductible	20% after deductible
Rx-non-preferred brand drugs (Tier 3)	\$80 after Rx deductible	\$100 after Rx deductible	20% after deductible
Rx-specialty drugs (Tier 4)	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	50% up to \$150 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP KP MD Gold Flexible Choice^(ie) 1,000 Ded/200 RxDed		
	Option 1 ¹	Option 2 ¹	Option 3 ¹
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	\$40	\$50	20% after deductible
Emergency room	\$500 after deductible	\$500 after deductible	\$500 after deductible
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	\$40	\$50	20% after deductible
Pediatric Dental Services			
Periodic oral evaluation	\$0 ²	Covered in plan	20%
Prophylaxis (cleaning)	\$0 ²	Covered in plan	20%
Topical application of fluoride	\$0 ²	Covered in plan	20%
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ²	Covered in plan	20%
Pediatric Vision Services			
Routine eye exam with optometrist	\$20	\$30	20% after deductible
Frames	No charge ³	Not available	40% after deductible
Lenses	No charge ³	Not available	40% after deductible
Contacts	No charge ⁴	Not available	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	\$20	\$30	20% after deductible
Frames	\$125 discount off retail price ⁵	Not available	40% up to \$100 after deductible
Lenses	\$125 discount off retail price ⁵	Not available	40% up to \$150 after deductible
Contacts	\$125 discount off retail price ⁵	Not available	40% up to \$50 after deductible

For details about (ie) and (iii), see the Definitions section on page 29.

¹Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).

²For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

³One pair per year from a selected group of frames.

⁴Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁵Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Gold Flexible Choice^(if) 1,750 Ded/HSA/Vision		
	Option 1 ¹	Option 2 ²	Option 3 ²
Individual plan annual deductible (subscriber only)	\$1,750	\$3,500	\$4,500
Family plan annual deductible (individual/family)	N/A (individual)/\$3,500	\$3,500/\$6,500	\$4,500/\$9,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$3,850	\$4,550	\$8,400
Family plan annual out-of-pocket maximum (individual/family)	\$3,850/\$7,700	\$4,550/\$9,100	\$8,400/\$16,800
Network ⁽ⁱⁱⁱ⁾	 Signature only	MultiPlan [®] and/or PHCS [™] , Cigna Healthcare SM PPO	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit	No charge after deductible	\$10 after deductible	20% after deductible
Specialty care office visit	\$20 after deductible	\$30 after deductible	20% after deductible
Preventive care/screening/immunization	No charge	No charge	20% after deductible
X-ray and lab diagnostic services	X-ray \$20/Lab \$5 (after deductible)	X-ray \$30/Lab \$10 (after deductible)	20% after deductible
MRI/CT/PET	\$100 after deductible	\$150 after deductible	20% after deductible
Telehealth	No charge after deductible	\$10 primary care physician/\$30 specialist (after deductible)	20% after deductible
Outpatient facility fee	\$100 after deductible	\$150 after deductible	20% after deductible
Mental health/chemical dependency outpatient services	Individual therapy: No charge Group therapy: No charge (after deductible)	\$10 individual therapy \$5 group therapy (after deductible)	20% after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	20% after deductible
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$200 per admission after deductible	\$250 per admission after deductible	20% after deductible
Prescription Drugs (30-day supply)			
Rx-deductible	Medical deductible applies	Medical deductible applies	Medical deductible applies
Rx-generic drugs (Tier 1)	\$10 after deductible	\$20 after deductible	20% after deductible
Rx-preferred brand drugs (Tier 2)	\$35 after deductible	\$45 after deductible	20% after deductible
Rx-non-preferred brand drugs (Tier 3)	\$55 after deductible	\$65 after deductible	20% after deductible
Rx-specialty drugs (Tier 4)	50% up to \$150 after deductible	50% up to \$150 after deductible	50% up to \$150 after deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP KP MD Gold Flexible Choice^(if) 1,750 Ded/HSA/Vision		
	Option 1 ¹	Option 2 ²	Option 3 ²
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	\$20 after deductible	\$30 after deductible	20% after deductible
Emergency room	\$400 after deductible (waived if admitted)	\$400 after deductible (waived if admitted)	\$400 after deductible (waived if admitted)
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	\$20 after deductible	\$30 after deductible	20% after deductible
Pediatric and Cosmetic Dental Services			
Periodic oral evaluation	\$0 ³	Covered in plan	20%
Prophylaxis (cleaning)	\$0 ³	Covered in plan	20%
Topical application of fluoride	\$0 ³	Covered in plan	20%
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ²	Covered in plan	20%
Pediatric Vision Services			
Routine eye exam with optometrist	No charge after deductible	\$10 after deductible	20% after deductible
Frames	No charge after deductible ³	Not available	40% after deductible
Lenses	No charge after deductible ⁴	Not available	40% after deductible
Contacts	No charge after deductible ⁴	Not available	40% after deductible
Adult Vision Services			
Routine eye exam with optometrist	No charge after deductible	\$10 after deductible	20% after deductible
Frames	Not covered	Not covered	Not covered
Lenses	Not covered	Not covered	Not covered
Contacts	Not covered	Not covered	Not covered

For details about (if) and (iii), see the Definitions section on page 29.

¹Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) underwrites the In-Network (Option 1), and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the In-Network PPO Tier (Option 2) and Out-of-Network Tier (Option 3).

²For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

³One pair per year from a selected group of frames.

⁴Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	
	 KP MD Gold 3,000 Ded/250 RxDed/Vision
Individual plan annual deductible (subscriber only)	\$3,000
Family plan annual deductible (individual/family)	\$3,000/\$6,000
Member coinsurance (plan pays/member pays),except as otherwise indicated	80%/20%
Individual plan annual out-of-pocket maximum (subscriber only)	\$8,000
Family plan annual out-of-pocket maximum (individual/family)	\$8,000/\$16,000
Network ⁽ⁱⁱⁱ⁾	 Signature or Select
HSA/HRA employer-required contribution	Not applicable
BENEFITS	
Outpatient Services	
Primary care office visit	\$25
Specialty care office visit	\$50
Preventive care/screening/immunization	No charge
X-ray and lab diagnostic services	X-ray \$40/Lab \$25
MRI/CT/PET	20% after deductible
Telehealth	No charge
Outpatient facility fee	20% after deductible
Mental health/chemical dependency outpatient services	\$25 individual therapy, \$12 group therapy
Maternity Services	
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge
Inpatient Services	
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	20% after deductible
Prescription Drugs (30-day supply)	
Rx–deductible	\$250
Rx–generic drugs (Tier 1)	\$15
Rx–preferred brand drugs (Tier 2)	\$50 after Rx deductible
Rx–non-preferred brand drugs (Tier 3)	\$65 after Rx deductible
Rx–specialty drugs (Tier 4)	50% up to \$150 after Rx deductible

GOLD PLAN SUMMARIES (Cont.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	
Urgent Care and Emergency Services	
Urgent care centers (after-hours urgent care)	\$50
Emergency room	20% after deductible
Therapy and Rehabilitation Services	
Habilitative and rehabilitative services	No charge after deductible
Pediatric Dental Services	
Periodic oral evaluation	\$5
cleaning	\$0
fluoride	\$0
Bitewing X-rays	\$0
Pediatric Vision services	
Routine eye exam with optometrist	\$25
Frames	No charge ¹
Lenses	No charge ²
Contacts	No charge ²
Adult Vision services	
Routine eye exam with optometrist	\$25
Frames	\$125 discount off retail price ³
Lenses	\$125 discount off retail price ³
Contacts	\$125 discount off retail price ³

For details about (iii), see the Definitions section on page 29.

¹ One pair per year from a selected group of frames.

² Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

³ Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

SILVER PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). For HMO Plus, services covered under out-of-network providers are subject to a 10-visit limit per member, per contract year (each visit counts); Rx is subject to a 5-fill/refill limit per member, per contract year (each fill/refill counts). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.

KP Offered through Kaiser Permanente **S** Offered through Small Business Options Program (SHOP), Maryland Health Connection

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP MD Silver ^(ia) 1,850 Ded/350 RxDed/ Vision	KP KP MD Silver Plus ^(ig) 1,850 Ded/350 RxDed/Vision		KP S KP MD Silver ^(ia) KP MD Silver 2,500 Ded/ 500 RxDed/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Individual plan annual deductible (subscriber only)	\$1,850	\$1,850	Not applicable	\$2,500
Family plan annual deductible (individual/family)	\$1,850/\$3,700	\$1,850/\$3,700	Not applicable	\$2,500/\$5,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	\$9,100	\$9,100	Not applicable	\$9,400
Family plan annual out-of-pocket maximum (individual/family)	\$9,100/\$18,200	\$9,100/\$18,200	Not applicable	\$9,400/\$18,800
Network ⁽ⁱⁱⁱ⁾	KP Signature or Select S Signature only	KP Signature only	Not applicable	KP Signature or Select S Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit	\$40	\$40	\$60 (applies to 10-visit limit)	\$40
Specialty care office visit	\$50 after deductible	\$65	\$85 (applies to 10-visit limit)	\$60
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	X-ray \$50/Lab \$40 (after deductible)	X-ray \$50/Lab \$40 (after deductible)	X-ray \$70/Lab \$60 (applies to 10-visit limit)	\$60
MRI/CT/PET	\$400 after deductible	\$400 after deductible	Not covered	\$400 after deductible
Telehealth	No charge	No charge	\$60 (applies to 10-visit limit)	No charge
Outpatient facility fee	\$350 after deductible	\$350 after deductible	Not covered	\$350 after deductible
Mental health/chemical dependency outpatient services	\$40 individual therapy \$20 group therapy	\$40 individual therapy \$20 group therapy	\$60 individual therapy \$30 group therapy (applies to 10-visit limit)	\$40 individual therapy \$20 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$500 per day up to 5 days per admission after deductible	\$500 per day up to 5 days per admission after deductible	Not covered	\$500 per day up to 5 days per admission after deductible

SILVER PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Silver ^(ia) 1,850 Ded/350 RxDed/ Vision	 KP MD Silver Plus ^(ig) 1,850 Ded/350 RxDed/Vision		 KP MD Silver ^(ia) KP MD Silver 2,500 Ded/ 500 RxDed/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Prescription Drugs (30-day supply)				
Rx—deductible	\$350	\$350	Not applicable	\$500
Rx—generic drugs (Tier 1)	\$20	\$20	\$40 (each fill/refill applies to the 5-prescription limit)	\$25
Rx—preferred brand drugs (Tier 2)	\$50 after Rx deductible	\$50 after Rx deductible	\$70 (each fill/refill applies to the 5-prescription limit)	\$60 after Rx deductible
Rx—non-preferred brand drugs (Tier 3)	50% after Rx deductible	50% after Rx deductible	60% (each fill/refill applies to the 5-prescription limit)	50% after Rx deductible
Rx—specialty drugs (Tier 4)	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	60% up to \$150 (each fill/refill applies to the 5-prescription limit)	50% up to \$150 after Rx deductible
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	\$50 after deductible	\$65	\$65	\$60
Emergency room	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	\$50 after deductible	\$50 after deductible	\$70 (applies to 10-visit limit)	\$60 after deductible
Pediatric Dental Services				
Periodic oral evaluation	\$5	\$5	Not covered	\$5
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Topical application of fluoride	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	Not covered	\$0 (no additional cost for 1 to 4 films) ¹
Pediatric Vision Services				
Routine eye exam with optometrist	\$40	\$40	Not covered	\$40
Frames	No charge ²	No charge ²	Not covered	No charge ²
Lenses	No charge ²	No charge ²	Not covered	No charge ²
Contacts	No charge ³	No charge ³	Not covered	No charge ³
Adult Vision Services				
Routine eye exam with optometrist	\$40	\$40	Not covered	\$40
Frames	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Lenses	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Contacts	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴

For details about (ia), (ig), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Silver^(ic) 2,000 Ded/HSA/Vision	 KP MD Silver^(ic) 3,000 Ded/HSA/Vision	 KP MD Silver^(ic) 4,000 Ded/HSA/Vision	 KP MD Silver Added Choice^(id) 2,500 Ded/500 RxDed	
				In-Network	Out-of-Network
Individual plan annual deductible (subscriber only)	\$2,000	\$3,000	\$4,000	\$2,500	\$4,500
Family plan annual deductible (individual/family)	N/A (individual)/\$4,000	N/A (individual)/\$6,000	\$4,000/\$8,000	\$2,500/\$5,000	\$4,500/\$9,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	100%/0%	100%/0%	70%/30%
Individual plan annual out-of-pocket maximum (subscriber only)	\$8,500	\$8,000	\$7,500	\$9,400	\$18,800
Family plan annual out-of-pocket maximum (individual/family)	\$8,500/\$17,000	\$8,000/\$16,000	\$7,500/\$15,000	\$9,400/\$18,800	\$18,800/\$37,600
Network ⁽ⁱⁱⁱ⁾	 Signature or Select  Signature only	 Signature or Select	 Signature or Select	 Signature or Select	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS					
Outpatient Services					
Primary care office visit	\$30 after deductible	\$30 after deductible	\$25 after deductible	\$40	\$70
Specialty care office visit	\$40 after deductible	\$50 after deductible	\$50 after deductible	\$60	\$120
Preventive care/screening/immunization	No charge	No charge	No charge	No charge	No charge after deductible
X-ray and lab diagnostic services	Lab \$40/X-ray \$50 (after deductible)	\$50 after deductible	No charge after deductible	\$60	\$80 after deductible
MRI/CT/PET	\$300 after deductible	\$400 after deductible	No charge after deductible	\$400 after deductible	\$500 after deductible
Telehealth	No charge after deductible	No charge after deductible	No charge after deductible	No charge	Applicable cost share will apply based on type of provider
Outpatient facility fee	\$300 after deductible	\$300 after deductible	\$250 after deductible	\$350 after deductible	\$450 after deductible
Mental health/chemical dependency outpatient services	\$30 individual therapy \$15 group therapy (after deductible)	\$30 individual therapy \$15 group therapy (after deductible)	\$25 individual therapy (after deductible) \$12 group therapy (after deductible)	\$40 individual therapy \$20 group therapy	\$70 individual therapy \$35 group therapy
Maternity Services					
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge	No charge	No charge after deductible
Inpatient Services					
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$500 per admission after deductible	\$500 per day up to 3 days per admission after deductible	\$500 per day up to 5 days per admission after deductible	\$500 per day up to 5 days per admission after deductible	\$600 per day up to 5 days per admission after deductible

SILVER PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Silver ^(ic) 2,000 Ded/HSA/Vision	 KP MD Silver ^(ic) 3,000 Ded/HSA/Vision	 KP MD Silver ^(ic) 4,000 Ded/HSA/Vision	 KP MD Silver Added Choice ^(id) 2,500 Ded/500 RxDed	
	In-Network		Out-of-Network		
Prescription Drugs (30-day supply)					
Rx—deductible	Medical deductible applies	Medical deductible applies	Medical deductible applies	\$500	Medical deductible applies
Rx—generic drugs (Tier 1)	\$20 after deductible	\$20 after deductible	\$20 after deductible	\$25	\$35 after deductible
Rx—preferred brand drugs (Tier 2)	\$50 after deductible	\$50 after deductible	\$50 after deductible	\$60 after Rx deductible	\$60 after deductible
Rx—non-preferred brand drugs (Tier 3)	50% after deductible	50% after deductible	50% after deductible	50% after Rx deductible	50% after deductible
Rx—specialty drugs (Tier 4)	50% up to \$150 after deductible	50% up to \$150 after deductible	50% up to \$150 after deductible	50% up to \$150 after Rx deductible	50% up to \$150 after deductible
Urgent Care and Emergency Services					
Urgent care centers (after-hours urgent care)	\$40 after deductible	\$50 after deductible	\$50 after deductible	\$60	\$120
Emergency room	\$400 after deductible (waived if admitted)	\$400 after deductible (waived if admitted)	\$350 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)
Therapy and Rehabilitation Services					
Habilitative and rehabilitative services	\$50 after deductible	\$50 after deductible	\$50 after deductible	\$60 after deductible	\$80 after deductible
Pediatric Dental Services					
Periodic oral evaluation	\$5	\$5	\$5	\$0 ¹	20%
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	\$0 ¹	\$0 ¹	20%
Topical application of fluoride	\$0 ¹	\$0 ¹	\$0 ¹	\$0 ¹	20%
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	20%
Pediatric Vision Services					
Routine eye exam with optometrist	\$30 after deductible	\$30 after deductible	\$25 after deductible	\$40	\$70
Frames	No charge after deductible ²	No charge after deductible ²	No charge after deductible ²	No charge ²	30% after deductible ²
Lenses	No charge after deductible ²	No charge after deductible ²	No charge after deductible ²	No charge ²	30% after deductible ²
Contacts	No charge after deductible ³	No charge after deductible ³	No charge after deductible ³	No charge ³	40% after deductible ²

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Silver ^(ic) 2,000 Ded/HSA/Vision	 KP MD Silver ^(ic) 3,000 Ded/HSA/Vision	 KP MD Silver ^(ic) 4,000 Ded/HSA/Vision	 KP MD Silver Added Choice ^(id) 2,500 Ded/500 RxDed	
	In-Network		Out-of-Network		
Adult Vision Services					
Routine eye exam with optometrist	\$30 after deductible	\$30 after deductible	\$25 after deductible	\$40	\$70
Frames	Not covered	Not covered	Not covered	\$125 discount off retail price ⁴	10% discount off retail price
Lenses	Not covered	Not covered	Not covered	\$125 discount off retail price ⁴	10% discount off retail price
Contacts	Not covered	Not covered	Not covered	\$125 discount off retail price ⁴	5% discount off retail price

For details about (ic), (id), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

SILVER PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Silver^(ia) 4,000 Ded/450 RxDed/Vision	 KP MD Silver Plus^(ig) 4,000 Ded/450 RxDed/Vision		 KP MD Silver 5,000 Ded/450 RxDed/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Individual plan annual deductible (subscriber only)	\$4,000	\$4,000	Not applicable	\$5,000
Family plan annual deductible (individual/family)	\$4,000/\$8,000	\$4,000/\$8,000	Not applicable	\$5,000/\$10,000
Member coinsurance (plan pays/member pays), except as otherwise indicated	100%/0%	100%/0%	Not applicable	70%/30%
Individual plan annual out-of-pocket maximum (subscriber only)	\$9,400	\$9,400	Not applicable	\$9,000
Family plan annual out-of-pocket maximum (individual/family)	\$9,400/\$18,800	\$9,400/\$18,800	Not applicable	\$9,000/\$18,000
Network ⁽ⁱⁱⁱ⁾	 Signature only	 Signature only	Not applicable	 Signature or Select
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable	Not applicable
BENEFITS				
Outpatient Services				
Primary care office visit	\$40	\$40	\$60 (applies to 10-visit limit)	\$50
Specialty care office visit	\$60	\$60	\$80 (applies to 10-visit limit)	\$75
Preventive care/screening/immunization	No charge	No charge	No charge (applies to 10-visit limit)	No charge
X-ray and lab diagnostic services	\$50 after deductible	\$50 after deductible	\$70 (applies to 10-visit limit)	X-ray \$50/Lab \$25 (after deductible)
MRI/CT/PET	\$400 after deductible	\$400 after deductible	Not covered	30% after deductible
Telehealth	No charge	No charge	\$60 (applies to 10-visit limit)	No charge
Outpatient facility fee	\$350 after deductible	\$350 after deductible	Not covered	30% after deductible
Mental health/chemical dependency outpatient services	\$40 individual therapy \$20 group therapy	\$40 individual therapy \$20 group therapy	\$60 individual therapy \$30 group therapy (applies to 10-visit limit)	\$50 individual therapy \$25 group therapy
Maternity Services				
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	Not covered	No charge
Inpatient Services				
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	\$500 per day up to 5 days per admission after deductible	\$500 per day up to 5 days per admission after deductible	Not covered	30% after deductible

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP KP MD Silver ^(ia) 4,000 Ded/450 RxDed/ Vision	KP KP MD Silver Plus ^(ig) 4,000 Ded/450 RxDed/Vision		KP KP MD Silver 5,000 Ded/ 450 RxDed/Vision
		Kaiser Permanente Providers	Out-of-Network Providers	
Prescription Drugs (30-day supply)				
Rx—deductible	\$450	\$450	Not applicable	\$450
Rx—generic drugs (Tier 1)	\$20	\$20	\$40 (each fill/refill applies to the 5-prescription limit)	\$20
Rx—preferred brand drugs (Tier 2)	\$50 after Rx deductible	\$50 after Rx deductible	\$70 (each fill/refill applies to the 5-prescription limit)	\$50 after Rx deductible
Rx—non-preferred brand drugs (Tier 3)	50% after Rx deductible	50% after Rx deductible	60% (each fill/refill applies to the 5-prescription limit)	50% after Rx deductible
Rx—specialty drugs (Tier 4)	50% up to \$150 after Rx deductible	50% up to \$150 after Rx deductible	60% up to \$150 (each fill/refill applies to the 5-prescription limit)	50% up to \$150 after Rx deductible
Urgent Care and Emergency Services				
Urgent care centers (after-hours urgent care)	\$60	\$60	\$60	\$75
Emergency room	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	\$500 after deductible (waived if admitted)	30% after deductible
Therapy and Rehabilitation Services				
Habilitative and rehabilitative services	\$50 after deductible	\$50 after deductible	\$70 (applies to 10-visit limit)	\$25 after Rx deductible
Pediatric Dental Services				
Periodic oral evaluation	\$5	\$5	Not covered	\$5
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Topical application of fluoride	\$0 ¹	\$0 ¹	Not covered	\$0 ¹
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	Not covered	\$0 ¹
Pediatric Vision Services				
Routine eye exam with optometrist	\$40	\$40	Not covered	\$50
Frames	No charge ²	No charge ²	Not covered	No charge ²
Lenses	No charge ³	No charge ³	Not covered	No charge ³
Contacts	No charge ³	No charge ³	Not covered	No charge ³
Adult Vision Services				
Routine eye exam with optometrist	\$40	\$40	Not covered	\$50
Frames	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Lenses	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴
Contacts	\$125 discount off retail price ⁴	\$125 discount off retail price ⁴	Not covered	\$125 discount off retail price ⁴

For details about (ia), (ig), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

BRONZE PLAN SUMMARIES

The following is a limited summary of benefits (and applicable member cost shares) offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This summary of benefits is for comparison purposes only and does not create rights not given through the benefit plan. These plans are “non-grandfathered health plans” under the Patient Protection and Affordable Care Act. Pediatric dental benefits are underwritten by KFHP-MAS and administered by LIBERTY Dental Plan. For details about the terms of coverage, including exclusions and limitations, please review the applicable *Evidence of Coverage (EOC)*.



Offered through Kaiser Permanente



Offered through Small Business Options Program (SHOP), Maryland Health Connection

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP MD Bronze^(ia) 6,500 Ded/Vision	KP MD Bronze^(ic) 6,150 Ded/HSA/Vision	KP MD Bronze^(ic) 7,100 Ded/HSA/Vision
Individual plan annual deductible (subscriber only)	\$6,500	\$6,150	\$7,100
Family plan annual deductible (individual/family)	\$6,500/\$13,000	\$6,150/\$12,300	\$7,100/\$14,200
Member coinsurance (plan pays/member pays), except as otherwise indicated	60%/40%	100%/0%	100%/0%
Individual plan annual out-of-pocket maximum (subscriber only)	\$10,000	\$8,100	\$7,100
Family plan annual out-of-pocket maximum (individual/family)	\$10,000/\$20,000	\$8,100/\$16,200	\$7,100/\$14,200
Network ⁽ⁱⁱⁱ⁾	Signature or Select Signature only	Signature or Select Signature only	Signature or Select Signature only
HSA/HRA employer-required contribution	Not applicable	Not applicable	Not applicable
BENEFITS			
Outpatient Services			
Primary care office visit	\$50	\$40 after deductible	No charge after deductible
Specialty care office visit	\$80	\$60 after deductible	No charge after deductible
Preventive care/screening/immunization	No charge	No charge	No charge
X-ray and lab diagnostic services	Lab \$60/X-ray \$100 (after deductible)	Lab \$50/X-ray \$75 (after deductible)	No charge after deductible
MRI/CT/PET	\$450 after deductible	\$400 after deductible	No charge after deductible
Telehealth	No charge	No charge after deductible	No charge after deductible
Outpatient facility fee	\$400 after deductible	\$350 after deductible	No charge after deductible
Mental health/chemical dependency outpatient	\$50 individual therapy \$25 group therapy	\$40 individual therapy \$20 group therapy (after deductible)	No charge after deductible
Maternity Services			
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	No charge	No charge
Inpatient Services			
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	40% after deductible	\$500 per admission after deductible	No charge after deductible

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP S KP MD Bronze^(ia) 6,500 Ded/Vision	KP S KP MD Bronze^(ic) 6,150 Ded/HSA/Vision	KP S KP MD Bronze^(ic) 7,100 Ded/HSA/Vision
Prescription Drugs (30-day supply)			
Rx—deductible	Medical deductible applies	Medical deductible applies	Medical deductible applies
Rx—generic drugs (Tier 1)	\$30	\$20 after deductible	No charge after deductible
Rx—preferred brand drugs (Tier 2)	\$65 after deductible	\$50 after deductible	No charge after deductible
Rx—non-preferred brand drugs (Tier 3)	50% after deductible	\$80 after deductible	No charge after deductible
Rx—specialty drugs (Tier 4)	50% up to \$150 after deductible	50% up to \$150 after deductible	No charge after deductible
Urgent Care and Emergency Services			
Urgent care centers (after-hours urgent care)	\$80	\$60 after deductible	No charge after deductible
Emergency room	40% after deductible	\$350 after deductible	No charge after deductible
Therapy and Rehabilitation Services			
Habilitative and rehabilitative services	\$80 after deductible	\$60 after deductible	No charge after deductible
Pediatric Dental Services			
Periodic oral evaluation	\$5	\$5	\$5
Prophylaxis (cleaning)	\$0 ¹	\$0 ¹	\$0 ¹
Topical application of fluoride	\$0 ¹	\$0 ¹	\$0 ¹
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹	\$0 (no additional cost for 1 to 4 films) ¹
Pediatric Vision Services			
Routine eye exam with optometrist	\$50	\$40 after deductible	No charge after deductible
Frames	No charge ²	No charge after deductible ²	No charge after deductible ²
Lenses	No charge ²	No charge after deductible ²	No charge after deductible ²
Contacts	No charge ³	No charge after deductible ³	No charge after deductible ³
Adult Vision Services			
Routine eye exam with optometrist	\$50	\$40 after deductible	No charge after deductible
Frames	\$125 discount off retail price ⁴	Not covered	Not covered
Lenses	\$125 discount off retail price ⁴	Not covered	Not covered
Contacts	\$125 discount off retail price ⁴	Not covered	Not covered

For details about (ia), (ic), and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	 KP MD Bronze Plus^(ig) 6,500 Ded/Vision	
	In-Network	Out-of-Network
Individual plan annual deductible (subscriber only)	\$6,500	Not applicable
Family plan annual deductible (individual/family)	\$6,500/\$13,000	Not applicable
Member coinsurance (plan pays/member pays), except as otherwise indicated	60%/40%	Not applicable
Individual plan annual out-of-pocket maximum (subscriber only)	\$10,000	Not applicable
Family plan annual out-of-pocket maximum (individual/family)	\$10,000/\$20,000	Not applicable
Network ⁽ⁱⁱⁱ⁾	 Signature only	Not applicable
HSA/HRA employer-required contribution	Not applicable	Not applicable
BENEFITS		
Outpatient Services		
Primary care office visit	\$50	\$70 (applies to 10-visit limit)
Specialty care office visit	\$80	\$100 (applies to 10-visit limit)
Preventive care/screening/immunization	No charge	No charge (applies to 10-visit limit)
X-ray and lab diagnostic services	X-ray \$100/Lab \$60 (after deductible)	X-ray \$120/Lab \$80 (applies to 10-visit limit)
MRI/CT/PET	\$450 after deductible	Not covered
Telehealth	No charge	\$70 (applies to 10-visit limit)
Outpatient facility fee	\$400 after deductible	Not covered
Mental health/chemical dependency outpatient	\$50 individual therapy/\$25 group therapy	\$70 individual therapy/\$35 group therapy (applies to 10-visit limit)
Maternity Services		
Routine prenatal visits (after confirmation of pregnancy) and postnatal visits	No charge	Not covered
Inpatient Services		
All inpatient hospital services (applies to all inpatient hospital stays for any reason)	40% after deductible	Not covered
Prescription Drugs (30-day supply)		
Rx–deductible	Medical deductible applies	Not applicable
Rx–generic drugs (Tier 1)	\$30	\$50 (each fill/refill applies to the 5-prescription limit)
Rx–preferred brand drugs (Tier 2)	\$65 after deductible	\$100 (each fill/refill applies to the 5-prescription limit)
Rx–non-preferred brand drugs (Tier 3)	50% after deductible	60% (each fill/refill applies to the 5-prescription limit)
Rx–specialty drugs (Tier 4)	50% up to \$150 after deductible	60% up to \$150 (each fill/refill applies to the 5-prescription limit)

BRONZE PLAN SUMMARIES (CONT.)

PLAN DETAILS Refer to Definitions, Exclusions, and Limitations at back of booklet for more details and information.	KP KP MD Bronze Plus^(ig) 6,500 Ded/Vision	
	In-Network	Out-of-Network
Urgent Care and Emergency Services		
Urgent care centers (after-hours urgent care)	\$80	\$80
Emergency room	40% after deductible	40% after deductible
Therapy and Rehabilitation Services		
Habilitative and rehabilitative services	\$80 after deductible	\$100 (applies to 10-visit limit)
Pediatric Dental Services		
Periodic oral evaluation	\$5	Not covered
Prophylaxis (cleaning)	\$0 ¹	Not covered
Topical application of fluoride	\$0 ¹	Not covered
Bitewing X-rays	\$0 (no additional cost for 1 to 4 films) ¹	Not covered
Pediatric Vision Services		
Routine eye exam with optometrist	\$50	Not covered
Frames	No charge ²	Not covered
Lenses	No charge ²	Not covered
Contacts	No charge ³	Not covered
Adult Vision Services		
Routine eye exam with optometrist	\$50	Not covered
Frames	\$125 discount off retail price ⁴	Not covered
Lenses	\$125 discount off retail price ⁴	Not covered
Contacts	\$125 discount off retail price ⁴	Not covered

For details about (ig) and (iii), see the Definitions section on page 29.

¹For more information and to obtain a copy of the applicable fee schedule, please visit kp.org/dental/mas.

²One pair per year from a selected group of frames.

³Limited to the initial purchase of the standard supply for type purchased or medically necessary contacts—\$0 copay, limited to two pairs per eye, per year, from a selected list of contacts.

⁴Adult vision hardware discount is available for frames and lenses combined and contact lenses once per year (365 days).

All cost sharing for listed services is applied to the out-of-pocket maximum. Please refer to your EOC for the complete list of services that are applied to the out-of-pocket maximum.

DEFINITIONS

(ia) Deductible HMO Plans

Deductible plans with family coverage have both an individual deductible and a family deductible. That means that one member of the family can meet the lower individual deductible and be eligible for coinsurance or copayments before the higher family deductible is satisfied. Similarly, one family member can meet the lower individual out-of-pocket maximum before the higher family out-of-pocket maximum is met. Services subject to the deductible are marked with “after deductible” along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(ib) HSA-Qualified Deductible HMO Plans

Under certain HSA-qualified deductible plans with family coverage, there is no individual member deductible or out-of-pocket maximum. Instead, all plans are subject to a family deductible or out-of-pocket maximum, which can be met by one or more family members contributing to a combined family deductible or out-of-pocket maximum. Once the combined contribution of all family members has reached the applicable deductible or out-of-pocket maximum, the deductible/out-of-pocket maximum will be satisfied for all family members for the remainder of the contract year. Services subject to the deductible are marked with “after deductible” along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(ic) HSA-Qualified Deductible HMO Plans

Under certain HSA-qualified deductible plans with family coverage, there is both an individual member deductible and out-of-pocket maximum. That means that one member of the family can meet the lower individual deductible and be eligible for coinsurance or copayments before the higher family deductible is satisfied. Similarly, one family member can meet the lower individual out-of-pocket maximum before the higher family out-of-pocket maximum is met. Services subject to the deductible are marked with “after deductible” along with the coinsurance or copayment amount the member will be responsible for paying once the deductible is met.

(id) Added Choice Plans

Added Choice point-of-service plans combine an in-network provider option with an out-of-network provider option. Members can switch between the

two provider network options at any time. Benefits vary between each option, and the cost sharing for a particular service depends on the provider option and, sometimes, where the member receives care.

(ie) Deductible Flexible Choice Plans

Deductible Flexible Choice plans allow members to receive care from: (1) Permanente physicians in the Mid-Atlantic Permanente Medical Group, P.C. (HMO); (2) from physicians in the PHCS™ or MultiPlan® networks when getting care in a Kaiser Permanente service area,¹ or from the Cigna HealthcareSM PPO Network when getting care outside a Kaiser Permanente service area; and (3) out-of-network from any other licensed provider. Benefit levels and cost shares vary according to the provider option. In general, the member's out-of-pocket costs may increase from HMO providers to PPO providers to out-of-network providers.

(if) HSA-Qualified Flexible Choice Plans

HSA-Qualified Flexible Choice plans can be paired with a health savings account (HSA), which allows members to set aside pretax dollars to pay for qualified medical expenses.

(ig) Kaiser Permanente Plus Plans

The Kaiser Permanente Plus and Deductible Kaiser Permanente Plus plans are traditional HMO/DHMO plans with an added benefit, called the out-of-network benefit, that gives members the ability to see any licensed provider in the nation for certain covered outpatient services annually (visit limits apply).

(iia) HSA-Qualified Deductible HMO Plans with Health Savings Accounts (HSA) or Health Reimbursement Arrangements (HRA)

These plans require that the employer open and contribute to a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) for employees. The contribution amounts are exact and defined by the plan.

(iii) Kaiser Permanente Signature

With the Kaiser Permanente Signature Delivery System, you receive quality care provided by our Permanente physicians—a network of physicians in the Mid-Atlantic Permanente Medical Group, P.C., who practice exclusively in our medical centers conveniently located throughout the covered Maryland, Virginia, and Washington, DC, service areas. You can choose a doctor at any time, for any reason, ensuring that your physician meets your needs. Our medical centers offer a range

of services in one location, including primary care, lab, X-ray, and pharmacy. For inpatient services, you have convenient access to contracted hospitals located throughout the service area. When you receive care, tests, and screenings in our medical centers, you can use [kp.org](https://www.kp.org) to email your doctor's office, check most lab results, schedule and cancel appointments, order prescription refills for mail delivery or pickup, and much more.

(iii) Kaiser Permanente Select

Building on our Signature physician network delivery system, Kaiser Permanente Select adds access to contracted community physicians in private practice. Members may choose a Permanente physician in the Mid-Atlantic Permanente Medical Group, P.C., or a community physician, and also have access to contracted hospitals located throughout the service area.

(iii) PHCS™ and MultiPlan® Provider Networks

Both participating provider networks for KPIC available in Option 2 of the Deductible Flexible Choice and HSA-Qualified Flexible Choice plans when getting care in a Kaiser Permanente service area.¹

The PHCS™ and MultiPlan® networks include physicians and health care practitioners and facilities available to Flexible Choice members via Kaiser Permanente Insurance Company's network access agreement. Not all PHCS™ and MultiPlan® network providers are included. For a list of network providers, go to multiplan.com/kpmas.

(iii) Cigna HealthcareSM PPO Network Provider Network in Option 2 of the Flexible Choice plans when getting care outside of a Kaiser Permanente service area.

The Cigna HealthcareSM PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration. Cigna Healthcare is an independent company and not affiliated with Kaiser Permanente Insurance Company or Kaiser Foundation Health Plan. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with Kaiser Permanente Insurance Company and Kaiser Foundation Health Plan. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

¹Kaiser Permanente service areas include the District of Columbia and the states of California, Colorado, Georgia, Hawaii, Maryland, Oregon, and Virginia.

MEDICAL EXCLUSIONS

This provision provides information on what Services the Health Plan will not pay for regardless of whether or not the Service is Medically Necessary.

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the **List of Benefits** in this section. 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. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Other services to the extent they are covered by any government unit, except for veterans in Veterans Administration or armed forces facilities for services received for which the recipient is liable.
5. Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. Except for the pediatric vision benefit in the **List of Benefits** in this section - the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal Care Services and Domiciliary Care Services.
8. Services rendered by a Health Care Practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother or sister.
9. Experimental Services. This exclusion does not apply to Services covered under the clinical trials benefit in the **List of Benefits** in this section.

10. Practitioner, Hospital or clinical Services related to radial keratotomy, myopic keratomileusis and surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
11. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the **List of Benefits** in this section.
12. Services incurred before the effective date of coverage for a Covered Person.
13. Services incurred after a Covered Person's termination of coverage, except as provided in **Section 6: Extension of Benefits**.
14. 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.
15. Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.
16. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment.
18. Except for a covered telehealth consultation, charges for telephone consultations, failure to keep a scheduled visit or completion of any form.
19. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.
20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in the **List of Benefits** in this section.
21. Travel, whether or not it is recommended by a Health Care Practitioner, except for:
 - a. Covered ambulance Services; and
 - b. Air travel in connection with a covered transplant for the recipient and a companion or two companions if recipient is under age 18, to and from the site of a covered organ transplant.
22. Except for Emergency Services and Urgent Care Service, services received while the Covered Person is outside of the United States.
23. Immunizations related to foreign travel.
24. Unless otherwise specified in the **List of Benefits** in this section, or the **Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix, Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix, Kaiser Permanente Smile SG Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile SG Dental POS Adult Dental Plan Rider, or Kaiser Permanente Smile SG Dental PPO Adult Dental Plan Rider; as applicable**: Dental work or treatment which includes Hospital or professional care in connection with:
 - a. The operation or treatment for the fitting or wearing of dentures;
 - b. Orthodontic care or malocclusion;
 - c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident; and
 - d. Dental implants.
25. Except as provided under the **Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix, Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix, Kaiser Permanente Smile SG Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile SG Dental POS Adult Dental Plan Rider, or Kaiser Permanente Smile SG Dental PPO Adult Dental Plan Rider, as applicable**: Accidents occurring while and as a result of chewing.
26. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting, unless these Services are deemed to be Medically Necessary.
27. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
28. Services to reverse voluntary, surgically induced infertility.
29. Treatment of sexual dysfunction not related to organic disease.
30. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
31. Non-human organs and their implantation.
32. Non-replacement fees for blood and blood products.
33. Lifestyle improvements or physical fitness programs, unless included in **List of Benefits** in this section.

34. Wigs or cranial prosthesis, except for one (1) Medically Necessary hair prosthesis as noted above in the **List of Benefits** in this section.
35. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
36. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
37. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the Services are payable under a medical expense payment provision of an automobile insurance policy.
38. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
39. Services for, or related to, the removal of an organ from a Covered Person for the purposes of transplantation into another person unless the:
 - a. Transplant recipient is covered under the Health Plan and is undergoing a covered transplant; and
 - b. Services are not payable by another carrier.
40. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
41. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
42. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
43. Private duty nursing, unless authorized by the Health Plan.
44. Any claim, bill or other demand or request for payment for health care Services determined to be furnished as a result of a referral prohibited by § 1-302 of the Health Occupations Article.
45. Worker's Compensation or Employer Liability: Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.

GENERAL LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, including in the Schedule of Coverage, no payment will be made under any benefit of the plan for Expenses Incurred in connection with the following:

1. Charges for services approved by or reimbursed by Health Plan.
2. Charges in excess of the Maximum Allowable Charge.
3. Services that are not Medically Necessary. This exclusion does not apply to preventive or other Covered Services specifically covered under the Group Policy.
4. Services performed or prescribed under the direction of a person who is not a health care practitioner.
5. Services that are beyond the scope of practice of the health care practitioner performing the service.
6. Services received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
7. Charges for services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
8. Charges for personal care services and domiciliary care services.
9. Charges for non-Emergency Services in an Emergency Department or Independent Freestanding Emergency Department to the extent that they exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether Emergency Services were rendered in connection with an Emergency Medical Condition will be determined by KPIC.
10. Covered Services other than Emergency Services outside the United States.
11. Except for Emergency Services, weekend admission charges for Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive, and does not include admissions for maternity.
12. Services provided by a health care practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother, or sister.
13. Charges for experimental services.
14. Charges from a practitioner, hospital, or for clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
15. Covered Services received outside the United States, if such confinement, treatment, services, or supplies are of the type and nature that are not available in the United States.
16. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, or occupational disease or similar law.
17. Injury or Sickness arising out of, or in the course of, past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
18. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
19. Services to reverse a voluntary sterilization procedure for an Adult or a Dependent minor.
20. Services for sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.
21. Medical or surgical treatment for reducing or controlling weight, except as provided under the Covered Services in the GENERAL BENEFITS section of this Certificate.
22. Services incurred before the effective date of coverage for a Covered Person.
23. Services incurred after a Covered Person's termination of coverage, except as provided in the Extension of Benefits provision.
24. Personal Care Services and Domiciliary Care Services.

25. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
26. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
27. Charges for telephone consultations except for services covered under Telehealth, failure to keep a scheduled visit, or completion of any form.
28. Inpatient admissions primarily for diagnostic studies, unless authorized by KPIC.
29. The purchase, examination, or fitting of hearings aids and supplies, and tinnitus maskers, unless otherwise specified under the Covered Services in the GENERAL BENEFITS section of this Certificate.
30. Immunizations related to foreign travel.
31. Dental care and dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, or medical condition, including surgery on the jawbone and radiation treatment. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment. This exclusion does not include visits for repairs or treatment of cleft lip, cleft palate or both. This exclusion also does not include: (1) surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part or (2) removable appliances for TMJ repositioning. In addition, this exclusion does not include visits for repairs or treatment of accidental injury to sound natural teeth when performed or rendered within six (6) months following the accident.
32. Routine foot care, except as set forth under the Covered Services in the GENERAL BENEFITS section of this Certificate.
33. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.
34. Inpatient admissions primarily for physical therapy, unless authorized by KPIC.
35. Treatment of sexual dysfunction not related to organic disease.
36. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.
37. Non-human organs and their implantation.
38. Non-replacement fees for blood and blood products.
39. Lifestyle improvements, including nutrition counseling, or physical fitness programs, Except as provided under the Covered Services in the GENERAL BENEFITS section of this Certificate.
40. Outpatient orthomolecular therapy, including non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Provider unless otherwise covered under this Plan or required by state or federal law.
41. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
42. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
43. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
44. Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person.
45. Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
46. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
47. Private hospital room, unless authorized by KPIC.
48. Private duty nursing, unless authorized by KPIC.
49. Experimental Services. This exclusion does not apply to services covered under clinical trials in the GENERAL BENEFITS section.
50. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
51. Care in an intermediate care facility. This is a level of care for which a Provider determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
52. Services for which no charge is normally made in the absence of insurance.
53. Any claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral as determined by the appropriate regulatory board.
54. Adult vision hardware in HDHP/HSA plans.
55. Services in connection with a Surrogacy Arrangement, except for otherwise Covered Services provided to a Covered Person who is a surrogate.

OUTPATIENT PRESCRIPTION DRUGS LIMITATIONS AND EXCLUSIONS

The following items are excluded from Outpatient Prescription Drug coverage in addition to any set forth in the **GENERAL LIMITATIONS AND EXCLUSIONS** section of this Certificate:

1. Administration of a drug or medicine;
2. Any drug or medicine administered as Necessary Services and Supplies (See the GENERAL DEFINITIONS section of this Certificate);
3. Drugs not approved by the FDA;
4. Drugs and injectables for the treatment of sexual dysfunction disorders regardless of cause, including but not limited to Inhibited Sexual Desire, Female

- Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation;
5. Drugs and injectables for the treatment of cosmetic services;
 6. Replacement of lost or damaged drugs and accessories;
 7. Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Covered Person's condition. In addition, this exclusion will not apply to routine patient care costs related to clinical trial if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has a meaningful potential to benefit the Covered Person. Additionally, this exclusion will not apply to off-label use of a FDA approved drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.
 8. Internally Implanted time-release drugs and medicines;
 9. Drugs associated with non-covered services;
 10. Infant formulas, except for amino acid-based elemental formulas and special food products to treat PKU as set forth as a limited benefit under the GENERAL BENEFITS section of this Certificate;
 11. Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency.
 12. Anorectic or any drug solely prescribed for the purpose of weight loss or weight loss management unless prescribed in the treatment of morbid obesity or, unless covered under the Preventive Services benefits as required by PPACA.
 13. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician unless otherwise required by state or federal law, or unless covered under the preventive Services benefits as required by PPACA [and, except as otherwise allowed for over-the-counter contraceptives as set forth under the Drugs Covered provision above].
 14. Biotechnology drugs and diagnostic agents. The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome.

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**).

Bàsɔ̀ò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsonj ni sonj, ninj ma kénngɛn yé, mbi èyem. Wò nànj **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** (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 Sprachassistentz 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 मुफ्त 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 kwesiri 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 yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', 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, kojí' 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**).

اردو (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 n sọ èdè Yorùbá, àwọn isẹ̀ ìrànlowọ̀ èdè tó fi kún àwọn ohun èlò ìrànlowọ̀ tó yẹ àti àwọn isẹ̀ láisí ìdíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-888-225-7202** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company 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: KPIC Civil Rights Coordinator, Grievance 1557, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736, telephone number 1-888-225-7202.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-888-225-7202** (TTY: **711**).

አማርኛ (Amharic) ያስተውሉ: አንግሊዘኛ የሚናገሩ ከሆነ፣ የቋንቋ አርዳታ አገልግሎቶች፣ ከክፍያ ነጻ፣ ለአርስዎ ይገኛሉ። ወደ **1-888-225-7202** ይደውሉ (TTY: **711**)።

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-225-7202** (TTY: **711**).

Ḑásó ò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké ñ Ḑàsóò-wùdù-po-nyò jũ ní, níf, à wuɖu kà kò dò po-poò béin ñ gbo kpáa. Ḑá **1-888-225-7202** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: যদি আপনি ইংরেজিতে কথা বলেন, আপনার জন্য ভাষা সহায়তা পরিষেবা, বিনামূল্যে উপলব্ধ। **1-888-225-7202** (TTY: **711**) এ কল করুন।

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言協助服務。請致電 **1-888-225-7202** (TTY: **711**)

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با شماره **1-888-225-7202** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-225-7202** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen eine kostenlose Sprachassistentz zur Verfügung. Bitte wählen Sie: **1-888-225-7202 (TTY: 711).**

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો ભાષા સહાય સેવાઓ, વિના મૂલ્યે, આના પર ઉપલબ્ધ છે તમે. **1-888-225-7202 (TTY: 711)** પર કોલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-225-7202 (TTY: 711).**

हिंदी (Hindi) ध्यान दें: यदि आप अंग्रेजी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-225-7202 (टीटीवाई: 711)** पर कॉल करें।

Igbo (Igbo) GEE NTI: Ọ bụrụ na i na asụ Igbo, ọrụ enyemaka nkowa asụsụ, du n'efu, dịjiri gi. Kpọọ **1-888-225-7202 (TTY: 711).**

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-225-7202 (TTY: 711).**

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-888-238-5742 (TTY: 711)**

日本語 (Japanese) 注意事項: 日本語を話される場合、言語支援サービスを無料でご利用いただけます。 **1-888-225-7202 (TTY: 711)**まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-225-7202 (TTY: 711)** 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hól'ó, koj'í' hódílnih **1-888-225-7202 (TTY: 711).**

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis de forma gratuita serviços linguísticos. Basta ligar para **1-888-225-7202 (TTY: 711).**

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните **1-888-225-7202 (TTY: 711).**

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-225-7202 (TTY: 711).**

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-225-7202 (TTY: 711).**

ไทย (Thai) โปรดทราบ: หากคุณพูดภาษาอังกฤษ คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร **1-888-225-7202 (TTY: 711).**

اردو (Urdu) خبردار: اگر آپ انگریزی زبان بولتے ہیں، تو لسانی معاونت کی خدمات، بلامعاوضہ، آپ کے لیے دستیاب ہیں۔ **1-888-225-7202 (TTY: 711)** پر کال کریں۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-225-7202 (TTY: 711).**

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun o. Pe **1-888-225-7202 (TTY: 711)**



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive, Hyattsville, MD 20785
2026SG0586 MAS 6/11/26-12/31/27