KAISER PERMANENTE® : **KP DC Standard Silver 4000/40/Dental** **Coverage for: Individual/Family | Plan Type: HMO**

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville. MD 20852

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5018 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-855-249-5018 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** Individual / **$8,000** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes.** Rx Deductible (Doesn't apply to Generic): **$250** Individual in network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$8,000** Individual / **$16,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.kp.org or call 1-855-249-5018 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 / visit, deductible does not apply	Not Covered	None
	Specialist visit	$80 / visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	No charge, deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$80 / visit, deductible does not apply	Not Covered	Lab is $60 / visit, deductible does not apply.
	Imaging (CT/PET scans, MRI's)	$300 / test, deductible does not apply	Not Covered	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.kp.org/ formulary.**	Generic drugs	$15 / prescription, deductible does not apply	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge, deductible does not apply for preventive drugs, contraceptives or oral chemotherapy drugs.
	Preferred brand drugs	$50 / prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge, deductible does not apply for preventive drugs, contraceptives or oral chemotherapy drugs.
	Non-preferred brand drugs	$70 / prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge, deductible does not apply for preventive drugs, contraceptives or oral chemotherapy drugs.
	Specialty drugs	$150 / prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge, deductible does not apply for oral chemotherapy.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$350 / visit	$350 / visit	Copay waived if admitted
	Emergency medical transportation	$350 / encounter	$350 / encounter	Non-licensed ambulance services not covered
	Urgent care	$90 / visit, deductible does not apply	$90 / visit, deductible does not apply	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fee	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit, deductible does not apply	Not Covered	Group Therapy is $20 / visit, dedcutible does not apply. All other Outpatient Services are No charge, deductible does not apply.
	Inpatient services	20% coinsurance	Not Covered	None
If you are pregnant	Office visits	No charge, deductible does not apply	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	$50 / visit, deductible does not apply	Not Covered	None
	Rehabilitation services	Inpatient: 20% coinsurance; Outpatient: $65 / visit, deductible does not apply	Not Covered	Inpatient: None; Outpatient: Cardiac Rehab limited to 90 consecutive days; Pulmonary Rehab limited to 1 program per lifetime.
	Habilitation services	$65 / visit, deductible does not apply	Not Covered	None
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 60 days per year.
	Durable medical equipment	20% coinsurance, deductible does not apply	Not Covered	None
	Hospice service	No charge, deductible does not apply	Not Covered	Limited to 180 days per eligibility period.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not Covered	One exam per year.
	Children's glasses	No charge, deductible does not apply	Not Covered	1 pair glasses/yr (single OR bifocal lenses) OR 1st purchase of contact lenses/yr OR 2 pair/eye/yr medically necessary contacts (select group of frames and contacts)
	Children's dental check-up	No charge, deductible does not apply	Not Covered	Discount fees apply to other services. $10 office visit copay applies / visit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care