



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.kp.org](http://www.kp.org) or by calling 800-777-7902.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <b>deductible</b> ?                   | <b>\$1,500</b> person / <b>\$3,000</b> family<br>Does not apply to Preventive Copay. Rx, Adult eyewear, and Adult Dental do not count toward the deductible. | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .   |
| Are there other <b>deductibles</b> for specific services? | Yes. Preferred & Non-preferred brand drugs.: <b>\$ 250</b> person in network.<br>There are no other specific <b>deductibles</b> .                            | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.   |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | For <b>preferred providers</b> <b>\$6,350</b> person / <b>\$12,700</b> family  | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| What is not included in the <b>out-of-pocket limit</b> ?  | Premiums, balance-billing charges, and health care this plan does not cover.   | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| Is there an overall annual limit on what the plan pays?   | No.  | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <b>network of providers</b> ?        | Yes. For a list of <b>preferred providers</b> , see <a href="http://www.kp.org">www.kp.org</a> or call 1-855-249-5018.                                       | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?         | Yes. You may self refer to certain specialists.  | This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .   |
| Are there services this plan doesn't cover?               | Yes.   | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .   |

**Questions:** Call 800-777-7902, TTY/TDD 1-301-879-6380 or visit us at [www.kp.org](http://www.kp.org). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformglossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformglossary.pdf) or call 800-777-7902 to request a copy.

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



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event   | Services You May Need                            | Your cost if you use an  |                        | Limitations & Exceptions   |
|--|--|--|------------------------|--|
|  |  | Preferred Provider   | Non-Preferred Provider |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | \$30 Copay   | Not Covered            | —————none—————   |
|  | Specialist visit                                 | \$50 Copay   | Not Covered            | —————none—————   |
|  | Other practitioner office visit                  | \$50 Copay   | Not Covered            | Chiro limited to 20 visits per condition per contract year.  |
|  | Preventive care/screening/immunization           | \$0 Copay  | Not Covered            | Cost-sharing will apply if non-preventive services are provided during a scheduled preventive visit.                   |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | \$30 Copay   | Not Covered            | —————none—————   |
|  | Imaging (CT/PET scans, MRIs)                     | \$250 Copay  | Not Covered            | per test, not per visit  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> . | Generic drugs                                    | Retail:\$15 Copay<br>Mail Order:\$30 Copay                                   | Not Covered            | Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge. |
|  | Preferred brand drugs                            | Retail:\$45 Copay after deductible<br>Mail Order:\$90 Copay after deductible | Not Covered            | Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge. |
|  | Non-preferred brand drugs                        | 30% Coinsurance after deductible   | Not Covered            | Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge. |

| Common Medical Event   | Services You May Need                          | Your cost if you use an  |                        | Limitations & Exceptions  |
|--|--|--|------------------------|---|
|  |  | Preferred Provider   | Non-Preferred Provider |   |
|  | Specialty drugs                                | Retail:\$45 Copay after deductible<br>Mail Order:\$90 Copay after deductible | Not Covered            | Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge.  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
|  | Physician/surgeon fees                         | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
| If you need immediate medical attention                                | Emergency room services                        | \$350 Copay  | \$350 Copay            | Copay waived if admitted  |
|  | Emergency medical transportation               | \$0 Copay  | \$0 Copay              | Non-licensed ambulance services not covered   |
|  | Urgent care                                    | \$50 Copay   | Not Covered            | —————none—————  |
| If you have a hospital stay  | Facility fee (e.g., hospital room)             | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
|  | Physician/surgeon fee                          | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services   | \$30 Copay   | Not Covered            | Group Therapy is \$15 copay.  |
|  | Mental/Behavioral health inpatient services    | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
|  | Substance use disorder outpatient services     | \$30 Copay   | Not Covered            | Group Therapy is \$15 copay.  |
|  | Substance use disorder inpatient services      | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |
| If you are pregnant  | Prenatal and postnatal care                    | \$0 Copay  | Not Covered            | Coverage refers to pre and postnatal visits after confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care. |
|  | Delivery and all inpatient services            | 30% Coinsurance after deductible   | Not Covered            | —————none—————  |

| Common Medical Event  | Services You May Need     | Your cost if you use an   |                        | Limitations & Exceptions  |
|---|---------------------------|---|------------------------|---|
|   |                           | Preferred Provider  | Non-Preferred Provider |   |
| <b>If you need help recovering or have other special health needs</b> | Home health care          | \$0 Copay   | Not Covered            | —————none—————  |
|   | Rehabilitation services   | Inpatient:30% Coinsurance after deductible<br>Outpatient:\$30 Copay | Not Covered            | Inpatient:None<br>Outpatient:PT/OT/ST limit of 30 visits per therapy per condition per yr.<br>Cardiac Rehab limit of 90 visits per therapy per contract yr of PT/OT/ST.<br>Pulmonary Rehab limit of 1 program per lifetime. |
|   | Habilitation services     | \$30 Copay  | Not Covered            | Limit of 30 visits for adults age 19 and over per contract year.  |
|   | Skilled nursing care      | 30% Coinsurance after deductible                                    | Not Covered            | Limited to 100 days per contract year.  |
|   | Durable medical equipment | 30% Coinsurance after deductible                                    | Not Covered            | —————none—————  |
|   | Hospice service           | 0% Coinsurance after deductible                                     | Not Covered            | —————none—————  |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$30 Copay  | Not Covered            | One exam per contract year.   |
|   | Glasses                   | \$0 Copay   | Not Covered            | 1 Pair per year (select group of frames)<br>Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic<br>Contacts limited to 3 months supply from selected list   |
|   | Dental check-up           | No Charge   | Not Covered            | One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-rays per yr, 1 set full mouth x-rays every 3 yrs.  |

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Long-Term/Custodial Nursing Home Care</li></ul> | <ul style="list-style-type: none"><li>• Non-Emergency Care when Travelling Outside the U.S.</li><li>• Private-Duty Nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul> |
|--|--|--|

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care with limits</li><li>• Hearing Aids with limits</li></ul> | <ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Routine Dental Services (Adult) with limits</li></ul> | <ul style="list-style-type: none"><li>• Routine Eye Exam (Adult)</li><li>• Routine Hearing Tests</li></ul> |
|--|---|--|

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-777-7902. You may also contact your state insurance department at 1-800-492-6116.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-866-444-3272.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 800-777-7902 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-777-7902 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打800-777-7902 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 800-777-7902 or TTY/TDD 1-301-879-6380

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,920
- Patient pays \$2,620

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Co-pays              | \$ 20          |
| Co-insurance         | \$ 900         |
| Limits or exclusions | \$ 200         |
| <b>Total</b>         | <b>\$2,620</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,920
- Patient pays \$2,480

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,300        |
| Co-pays              | \$1,100        |
| Co-insurance         | \$ 0           |
| Limits or exclusions | \$ 80          |
| <b>Total</b>         | <b>\$2,480</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.