




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? | \$2,000 Individual / \$4,000 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$5,300 Individual / \$10,600 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 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 | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 / visit, deductible does not apply | Not covered | \$20 for the first three visits, deductible does not apply then \$20 after deductible (subject to combined VC PCP cost share limit). Copayment waived for children under age 5. |
| | Specialist visit | \$50 / visit | 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) | X-ray: 20% coinsurance ; Lab: \$50 / visit, deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| 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 (Tier 1) | \$20 / prescription at Plan Pharmacy and Mail Order , deductible does not apply \$30 / prescription at Participating Pharmacy , deductible does not apply | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies . Up to a 90-day supply for 1.5 copays through Mail Order. No charge, deductible does not apply for preventive drugs and contraceptives. |
| | Preferred brand drugs (Tier 2) | 20% / prescription at Plan Pharmacy and Mail Order , 20% / prescription at Participating Pharmacy . | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies . Up to a 90-day supply for 1.5 copays through Mail Order. No charge, deductible does not apply for preventive drugs and contraceptives. |
| | Non-preferred drugs (Tier 3) | 20% / prescription at Plan Pharmacy and Mail Order , 20% / prescription at Participating Pharmacy . | Not covered | Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies . Up to a 90-day supply for 1.5 copays through Mail Order. No charge, deductible does not apply for preventive drugs and contraceptives. |
| | Specialty drugs (Tier 4) | 50% coinsurance / prescription at Plan Pharmacy and Mail Order ; 50% coinsurance prescription at Participating Pharmacy | Not covered | Up to a \$300 max per 30-day supply or up to a \$600 max per 90-day supply. |
| 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 | 20% coinsurance | 20% / visit | None |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | \$50 / visit | Not covered | Non- plan providers are covered only outside the service area: \$50 / visit deductible does not apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | Emergency admissions covered for non- plan providers |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Emergency services covered for non- plan providers . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20/ individual visit; \$10 / group visit, deductible does not apply | Not covered | \$20 for the first three visits; then \$20 after deductible Individual therapy/ \$10 for the first three visits; then \$10 group therapy after deductible (subject to combined VC PCP cost share limit). |
| | 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 |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | None |
| | Rehabilitation services | \$50 / visit | Not covered | Outpatient: PT/ST/OT limit of 30 visits / therapy / condition / year. |
| | Habilitation services | \$50 / visit | Not covered | Limited to 30 visits each for PT/ST/OT/year. Early Intervention: No visit limits for children under age 3. |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 100 days / stay. |
| | Durable medical equipment | 20% coinsurance | Not covered | None |
| | Hospice services | No charge | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | No charge / Optometrist visit; deductible does not apply \$50 / Ophthalmologist visit. | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge, deductible does not apply | Not covered | 1 pair of glasses / year or 1 st purchase of contact lenses / year or 2 pair / eye / year medically necessary contacts (from 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
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Weight Loss Programs
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care (30 visits / condition / year. The visit limit applies separately for Habilitative and Rehabilitative services)
- Routine eye care (Adult)
- Private Duty Nursing
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agency in the chart below:

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

| | |
|--|---|
| Kaiser Permanente Member Services | 1-855-249-5018 (TTY: 711) or www.kp.org/memberservices |
| Department of Labor's Employee Benefits Security Administration | 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or www.cciio.cms.gov |
| Virginia Bureau of Insurance | 1-877-310-6560 or www.scc.virginia.gov/boi |

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-249-5018 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5018 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5018 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-855-249-5018 (TTY: 711).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|--------|
| ■ The plan's overall deductible | \$2000 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other (blood work) copayment | \$50 |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$10 |
| Coinsurance | \$1,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,370 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|--------|
| ■ The plan's overall deductible | \$2000 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other (blood work) copayment | \$50 |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$400 |
| Copayments | \$200 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,400 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|--------|
| ■ The plan's overall deductible | \$2000 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | \$500 |
| ■ Other (x-ray) copayment | \$50 |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2000 |
| Copayments | \$300 |
| Coinsurance | \$60 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,360 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-777-7902** (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, 2101 East Jefferson St., Rockville, MD 20852, 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>.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ḃàsóò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: Ǿ jǔ ké m̄ Ḃàsóò-wùdù-po-nyò jǔ ní, níí, à wudu kà kò dò po-poò béin m̄ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902** (TTY: **711**)。

فارسی (Farsi) توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: 711) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-777-7902** (TTY: 711).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: 711).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: 711).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: 711) पर कॉल करें।

Igbo (Igbo) NRUBAMA: O bụrụ na i na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijiri gi. Kpọọ **1-800-777-7902** (TTY: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: 711).

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。 **1-800-777-7902** (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. **1-800-777-7902** (TTY: 711) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánífti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih **1-800-777-7902** (TTY: 711).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (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 **1-800-777-7902** (TTY: 711).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: 711).

اردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-800-777-7902** (TTY: 711)۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: 711).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: 711).