Pick the right plan for you

We offer several types of health coverage for individuals and families. All feature quality care — the main difference is how you pay for it. Many preventive care services are no charge, no matter which plan you choose.

COPAYMENT PLANS

- No medical deductible
- Set charges for doctor's office visits

With copayment plans, you pay specific charges (or copays) for certain covered services, so you know your out-of-pocket costs for doctor's office visits and prescriptions in advance.

Our copayment plans:

– KP 0/25/Rx

– KP 0/35/Rx

DEDUCTIBLE PLANS

- Annual deductibles
- Lower premiums

Some people prefer paying a lower monthly premium in exchange for an annual deductible. With a deductible plan, you pay full charge for certain covered services until you meet the deductible. Then you're eligible to pay coinsurance (or a percentage of the charges) for those services.

Our deductible plans:

– KP 750/30/Rx

– KP 1000/30/Rx

– KP 1500/30

– KP 2000/30/Rx

– KP 4500/20%/Rx

– KP 8000/0%/Rx

HSA-QUALIFIED DEDUCTIBLE PLANS

- Annual deductibles
- Pay for health care with tax-deductible dollars[1]

HSA-qualified plans are a type of deductible plan that allows you to pay for most medical expenses with tax-deductible dollars. To take advantage of this plan, you would open a health savings account (or HSA) and use that account for eligible medical expenses.

Our HSA-qualified plans:

– KP 1250/20/HSA/Rx

– KP 2500/30/HSA/Rx

[1]Tax references relate to federal income tax only. Please consult a tax adviser for tax savings information.

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

12676 (12/1/12–12/31/13)
60092601 MAS 2013

How copayment plans work

Copayment plans are the simplest to use and to understand. No services are subject to a medical deductible. With copayment plans, you pay set charges (or copays) for certain covered services so you know your out-of-pocket costs for doctor's visits, prescriptions, etc., in advance. And since no services are subject to a medical deductible, you can pay copayments for most covered services starting with your first visit.

Using a copayment plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP 0/25/Rx plan, you would pay a $25 copay for the primary care office visit and a $40 copay for the X-ray. You would pay full charge for your prescriptions until you meet your $100 pharmacy deductible, and $10 for generic drugs after you have met your pharmacy deductible. Most copays contribute to your out-of-pocket maximum.

No surprises.

Benefit highlights

	COPAYMENT PLANS	
	KP 0/25/Rx	**KP 0/35/Rx**
FEATURES	**Most copays contribute to the out-of-pocket maximum.**	
Annual deductible (individual/family)	None	
Annual out-of-pocket maximum (individual/family)	$3,500/$7,000	$4,000/$8,000
BENEFITS		
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit	$25 copay[1]	$35 copay[1]
Specialty care office visit	$40 copay	$50 copay
Outpatient surgery	$100 copay	$300 copay
Diagnostic labs and X-rays	$40 copay	$50 copay
MRI, CT, and PET	$100 copay per test	
INPATIENT HOSPITAL CARE		
Hospital care and professional visits (no limit per admission)	$500 copay per day	$600 copay per day
MATERNITY COVERAGE		
Routine prenatal visits	No charge	
Routine postpartum and other prenatal visits	No charge	
Delivery and inpatient well-baby care	$500 copay per day	$600 copay per day
EMERGENCY AND URGENT CARE		
Emergency Department visit (waived if admitted)	$150 copay	
Urgent care visit (after hours)	$40 copay	$50 copay
PRESCRIPTION DRUGS	(30-day supply filled at a Kaiser Permanente pharmacy)	
Pharmacy deductible (all drugs)	$100 per member	$150 per member
Generic drug	$10 copay (after pharmacy deductible)	$15 copay (after pharmacy deductible)
Preferred brand/Nonpreferred brand drug	$30 copay/$45 copay (after pharmacy deductible)	
Contraceptives	No charge	
OTHER		
Dental services	$30 copay for preventive care services. See the "Dental Plan" section for more information.	

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Under the Affordable Care Act, your coverage will be considered non-grandfathered coverage because you purchased a Kaiser Permanente for Individuals and Families plan after March 23, 2010.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and rate you pay under your plan, or ask you to select a new plan. In any case, we will notify you in advance and provide options for you to continue your coverage without a break.

[1]Waived for children under age 5

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

12677 (12/1/12–12/31/13)
60092511 MAS 2013

How deductible plans work

Deductible plans generally offer lower monthly premiums in exchange for paying more out of your own pocket for services covered by your health plan. With a deductible plan, you pay full charge for certain covered services until your expenses meet an annual deductible. Then, for covered services, you pay a coinsurance or copay.

Deductibles

Under a traditional deductible plan, certain covered services are subject to the deductible—the set amount for which you pay full charge in a contract year. This means you'll pay full charge for those services until you reach your annual deductible.

No deductible for many services

With some of our traditional deductible plans, many services are available for a copay— even before you reach your deductible.

With these deductible plans, services such as primary care, specialty care, and urgent care visits are available for a copayment before you meet your deductible.

And to encourage you to receive preventive care, many of these services are available for no charge before you meet your deductible.

Out-of-pocket maximums

Your out-of-pocket maximum puts a cap on how much you'll spend on most covered services each contract year. This helps protect you financially if you have a serious illness or injury.

In all our deductible plans, the deductible applies toward the out-of-pocket maximum.

For example, if you are a single subscriber on the KP 2000/30/Rx plan, you would pay full charge for most services until your out-of-pocket costs reach $2,000 to meet your deductible. Then, you would pay an additional $2,000 in copays and coinsurance to reach your $4,000 out-of-pocket maximum. After you reach your $4,000 out-of-pocket maximum, you won't have to pay any deductibles, copays, or coinsurance for most covered services for the rest of the contract year.

60092602 MAS 2013

Using a deductible plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP 2000/30/Rx plan, you have to pay $2,000 out of pocket before you are eligible to pay a copay or coinsurance for most covered services.

In this example, even if you have not met your deductible, you would pay a $30 copayment (or copay) for the doctor's office visit because this service is not subject to the deductible under this plan. These copays would contribute toward your out-of-pocket maximum but not toward your deductible.

However, if you haven't met your medical deductible, you would pay full charge for the X-ray. And you would also pay full charge for the prescription until you meet the pharmacy deductible. The amount you pay for the X-ray would be applied to your $2,000 medical deductible. And the amount you pay for the generic drug would be applied to your $200 pharmacy deductible.

Visit the treatment fee tool at **kp.org/treatmentestimates** to estimate your out-of-pocket costs for upcoming services.

The HSA difference

Some of our deductible plans are HSA-qualified deductible plans. These plans can be paired with an optional health savings account, or HSA. HSA-qualified plans work similarly to traditional deductible plans with just a few differences:

- If you're eligible, you can open an HSA with an HSA-qualified plan.
- Money you deposit into your HSA is deductible on your federal income tax form.
- You can use funds from your HSA to pay for qualified medical expenses.

Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. To learn more about health savings accounts, visit www.irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

60092602 MAS 2013

Benefit highlights

	DEDUCTIBLE PLANS			
	KP 750/30/Rx	KP 1000/30/Rx	KP 1500/30	KP 2000/30/Rx
FEATURES	The deductible and most coinsurance and copays contribute to the out-of-pocket maximum.			
Annual deductible (individual/family)	$750/$1,500	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000
Annual out-of-pocket maximum (individual/family)	$3,500/$7,000			$4,000/$8,000
BENEFITS	Services not subject to deductible unless otherwise indicated			
PREVENTIVE CARE				
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.				
OUTPATIENT SERVICES (per visit or procedure)				
Primary care office visit	$30 copay[1]			
Specialty care office visit	$40 copay			
Outpatient surgery	20% of AC* (after deductible)		30% of AC (after deductible)	
Diagnostic labs and X-rays	20% of AC (after deductible)		30% of AC (after deductible)	
MRI, CT, and PET	20% of AC (after deductible)		30% of AC (after deductible)	
INPATIENT HOSPITAL CARE				
Hospital care and professional visits	20% of AC (after deductible)		30% of AC (after deductible)	
MATERNITY COVERAGE				
Routine prenatal visits	No charge			
Routine postpartum and other prenatal visits	No charge			
Delivery and inpatient well-baby care	20% of AC (after deductible)		30% of AC (after deductible)	
EMERGENCY AND URGENT CARE				
Emergency Department visit (waived if admitted)	$150 copay			
Urgent care visit (after hours)	$40 copay			
PRESCRIPTION DRUGS	(30-day supply filled at a Kaiser Permanente pharmacy)			
Pharmacy deductible (all drugs)	$100 per member	$150 per member	N/A	$200 per member
Generic drug	$10 copay (after pharmacy deductible)		Not covered	$10 copay (after pharmacy deductible)
Preferred brand/Nonpreferred brand drug	$30 copay/$45 copay (after pharmacy deductible)		Not covered	$35 copay/$50 copay (after pharmacy deductible)
Contraceptives	No charge			
OTHER				
Dental services	$30 copay for preventive care services. See the "Dental Plan" section for more information.			

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[1]Waived for children under age 5

***AC is the allowable charge.**

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

Benefit highlights

	DEDUCTIBLE PLANS	
	KP 4500/20%/Rx	**KP 8000/0%/Rx**
FEATURES	**The deductible and most coinsurance and copays contribute to the out-of-pocket maximum.**	
Annual deductible (individual/family)	$4,500/$9,000	$8,000/$16,000
Annual out-of-pocket maximum (individual/family)	$9,000/$18,000	$10,000/$20,000
BENEFITS	**Services not subject to deductible unless otherwise indicated**	
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit	20% of AC* (after deductible)	No charge (after deductible)
Specialty care office visit	20% of AC (after deductible)	No charge (after deductible)
Outpatient surgery	20% of AC (after deductible)	No charge (after deductible)
Diagnostic labs and X-rays	20% of AC (after deductible)	No charge (after deductible)
MRI, CT, and PET	20% of AC (after deductible)	No charge (after deductible)
INPATIENT HOSPITAL CARE		
Hospital care and professional visits	20% of AC (after deductible)	No charge (after deductible)
MATERNITY COVERAGE		
Routine prenatal visits	No charge	
Routine postpartum and other prenatal visits	No charge (after deductible)	
Delivery and inpatient well-baby care	20% of AC (after deductible)	No charge (after deductible)
EMERGENCY AND URGENT CARE		
Emergency Department visit (waived if admitted)	20% of AC (after deductible)	No charge (after deductible)
Urgent care visit (after hours)	20% of AC (after deductible)	No charge (after deductible)
PRESCRIPTION DRUGS	(30-day supply filled at a Kaiser Permanente pharmacy)	
Pharmacy deductible (all drugs)	Subject to medical deductible	
Generic drug	$15 copay (after deductible)	
Preferred brand/Nonpreferred brand drug	$35 copay/$50 copay (after deductible)	
Contraceptives	No charge	
OTHER		
Dental services	$30 copay for preventive care services. See the "Dental Plan" section for more information.	

These are only highlights of plan coverage and are not inclusive. For specific benefit information, reference the *Guide to Your 2013 Benefits and Services (KFHP-NG-KPIF-DC* for District of Columbia residents, *KFHP-NG-KPIF-VA* for Virginia residents, and *KFHP-NG-KPIF-MD* for Maryland residents), which you will receive upon acceptance. Please call Member Services at 301-468-6000 or 1-800-777-7902 for additional assistance. For a list of exclusions and limitations associated with the benefits shown, please see the "Exclusions and Limitations" section.

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The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and rate you pay under your plan, or ask you to select a new plan. In any case, we will notify you in advance and provide options for you to continue your coverage without a break.

***AC is the allowable charge.**

How HSA-qualified deductible plans work

An HSA-qualified plan is a deductible plan that is eligible to be paired with an optional health savings account, or HSA. If you sign up for an HSA-qualified deductible plan and open an HSA, you can pay for qualified medical expenses with tax-deductible dollars.[1]

An HSA-qualified plan works much like a traditional deductible plan. However, with an HSA-qualified plan, you pay full charge for all services (except certain preventive care services) until you meet your deductible. Then you are eligible to pay copayments or coinsurance for covered services for the rest of the contract year.

You can also save money with HSA-qualified plans because you can pay for qualified medical expenses — even those not covered by your health plan — with tax-deductible dollars. However, qualified expenses not covered by your health plan will not contribute to your deductible or out-of-pocket maximum.

All you have to do is:

- Sign up for an HSA-qualified health plan.
- If you are eligible, open a health savings account.
- Contribute tax-deductible dollars to this account.[2]
- Use those tax-free funds to pay for qualified health care expenses.

What you don't use rolls over to the next year and continues earning interest.[3]

Advantages of opening an HSA

- **Portability** The money belongs to you, so if you change health plans, you can take your HSA with you.
- **Rollover of unused funds** There is no "use it or lose it" restriction each year. What you don't use stays in your account until you are ready to use it.[3]
- **Control** You decide when to put the money in and when to take it out.
- **Retirement savings** The money in your account can be invested through the institution where you open it. And after age 65, you can use the funds, taxed at your ordinary income rate, for any reason without penalties.
- **Flexibility** You can use the money in your HSA to pay for qualified medical expenses, even those your deductible plan does not cover.

[1] Tax references relate to federal income tax only. The tax treatment of health savings account contributions and distributions under state income tax laws differs from the federal tax treatment. Consult with your financial or tax adviser for more information.

[2] For 2013, the federally established maximum contribution for an eligible individual with self-only coverage is $3,250. The annual maximum contribution for an eligible individual with family coverage is $6,450. This annual maximum is indexed annually for inflation. Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser.

[3] Earnings vary depending on the type of investment plan you opt for and/or the HSA provider you choose. Amount earned is based on the investment plan and market value, and in some instances, the account may actually lose money.

60092602 MAS 2013

Using a health savings account

What are qualified medical expenses?

You can use an HSA to pay for deductibles and many supplies and services not covered by your health plan. Generally, these are expenses that would qualify for the medical and dental expense deduction on your income tax.

Here are just a few examples of HSA-qualified expenses:

- Eyeglasses and laser eye surgery
- Dental care
- Acupuncture
- Chiropractic services
- Hearing aids

For a complete list, see Publication 502, Medical and Dental Expenses at www.irs.gov.

Who's eligible for an HSA?

To be eligible for an HSA, you need to meet the following requirements:

- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not a qualified deductible plan (with certain exceptions).
- You can't have received benefits from the Department of Veterans Affairs in the past three months.

You may set up your HSA through any financial institution that offers these accounts.[1]

An HSA offers triple tax advantages

- Tax-deductible contributions to your account
- Tax-free investment earnings[2]
- Tax-free withdrawals when funds are used for qualified medical expenses

Using an HSA-qualified deductible plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

With our HSA-qualified plans, you pay full charge for all covered services (except many preventive care services) until you meet your deductible. On the KP 1250/20/HSA/Rx plan, the deductible for an individual is $1,250, so you would need to pay $1,250 out-of-pocket to meet the deductible.

The good news is that the deductible contributes toward the $3,000 out-of-pocket maximum in this plan. So, after spending $3,000 out of pocket, you would not have to pay any charge for covered services for the rest of the year.

In this example, if the total costs you have paid out of pocket so far this contract year for covered services have not met your deductible, you would pay full charge for the doctor's office visit, the X-ray, and the medication. All the costs you pay for covered services would apply to your deductible, and your deductible would contribute to your out-of-pocket maximum.

If you have met your $3,000 out-of-pocket maximum, the doctor's office visit, the X-ray, and the generic medication would be no charge under this plan.

And, if you opened an HSA, you would be able to pay for these services with tax-free dollars. (Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. For more information on health savings accounts, please visit www.irs.gov/publications/p969/ar02.html.)

[1] Kaiser Permanente does not provide or administer financial products, including HSAs, and does not offer financial, tax, or investment advice. Members are responsible for their own investment decisions. If a member uses his or her HSA debit card to pay for something other than a qualified medical expense, the expenditure is subject to tax and, for individuals who are not disabled or over 65, a 20 percent tax penalty.

[2] Investment losses may occur with HSA accounts. Earnings vary depending on the type of investment plan you choose and/or the HSA provider you choose.

60092602 MAS 2013

Benefit highlights

	HSA-QUALIFIED DEDUCTIBLE PLANS	
	KP 1250/20/HSA/Rx	KP 2500/30/HSA/Rx
FEATURES	**The deductible, coinsurance, and copays contribute to the out-of-pocket maximum.**	
Annual deductible (individual/family)	$1,250/$2,500	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$3,000/$6,000	$5,000/$10,000
BENEFITS	**Services not subject to deductible unless otherwise indicated**	
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit	$20 copay (after deductible)[1]	$30 copay (after deductible)[1]
Specialty care office visit	$30 copay (after deductible)	$40 copay (after deductible)
Outpatient surgery	20% of AC* (after deductible)	
Diagnostic labs and X-rays	20% of AC (after deductible)	
MRI, CT, and PET	20% of AC (after deductible)	
INPATIENT HOSPITAL CARE		
Hospital care and professional visits	$500 copay per day (after deductible)	
MATERNITY COVERAGE		
Routine prenatal visits	No charge	
Routine postpartum and other prenatal visits	No charge (after deductible)	
Delivery and inpatient well-baby care	$500 copay per day (after deductible)	
EMERGENCY AND URGENT CARE		
Emergency Department visit (waived if admitted)	20% of AC (after deductible)	
Urgent care visit (after hours)	$30 copay (after deductible)	$40 copay (after deductible)
PRESCRIPTION DRUGS	(30-day supply filled at a Kaiser Permanente pharmacy)	
Pharmacy deductible (all drugs)	Subject to medical deductible	
Generic drug	$10 copay (after deductible)	$15 copay (after deductible)
Preferred brand/Nonpreferred brand drug	$35 copay/$50 copay (after deductible)	
Contraceptives	No charge	
OTHER		
Dental services	$30 copay for preventive care services. See the "Dental Plan" section for more information.	

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[1]Waived for children under age 5

***AC is the allowable charge.**

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

12678 (12/1/12–12/31/13)
60092602 MAS 2013

A reason to smile

We emphasize healthy smiles through preventive care. Our Preventive Dental Plan, available through Dominion Dental Services USA, Inc. (Dominion), promotes healthy teeth and gums to help reduce the need for costly procedures in the future.

You pay a $30 copayment for preventive care procedures such as routine cleanings, oral examinations, and topical fluoride, plus bitewing X-rays.

More extensive care is provided at fees up to 70 percent lower than the usual and customary charges for these services. You pay only the amount listed on the Dominion fee schedule. The combination of predictable costs, no deductibles, and no annual maximums helps you plan for out-of-pocket fees.

Choosing a dentist

You may choose any general dentist from the list of participating dental providers. Specialty care is also available. To see a participating specialist, you'll need a referral from a participating general dentist. These dentists are conveniently located throughout the community.

To locate a participating provider, please visit **dominiondental.com/kaiserdentists** or call Dominion at **1-888-518-5338**.

Quality dental care

With the Preventive Dental Plan, you can be confident that your dentist was carefully selected to offer quality care. All dentists go through a quality assurance program developed in accordance with the National Committee for Quality Assurance (NCQA). This process confirms that each dentist has the required credentials and has passed a thorough on-site office evaluation.

Dedicated customer service

We also know that quality customer service is an important component of any dental plan. To answer your questions about coverage, locating a provider, fee schedules, or other topics, knowledgeable Dominion Member Services representatives are available at **1-888-518-5338** to assist you, 7:30 a.m. to 6 p.m., Monday through Friday. (For TTY relay service, dial **711**.)

12679 (12/1/12–12/31/13)
60092603 MAS 2013

Important details and notices

HIPAA INFORMATION

Kaiser Permanente may have a health coverage plan for you even if you don't qualify for a plan that requires medical review. **If you live in Virginia or Washington, DC**, you may be eligible for Health Insurance Portability and Accountability Act (HIPAA) coverage. HIPAA is a federally mandated program that may apply to you if you have been turned down for medical coverage. **If you live in Maryland**, you may be eligible for health care coverage under the Maryland Health Insurance Plan (MHIP). MHIP is a program for Maryland residents who otherwise do not have access to health coverage.

For residents of Virginia and Washington, DC

If you believe that you are HIPAA eligible and have indicated that on your application, and if you or your family members do not pass the Kaiser Permanente for Individuals and Families medical review, your application(s) will be forwarded to our HIPAA Membership Administration department to determine if you or your family members qualify for HIPAA coverage. To learn more about HIPAA eligibility and coverage, please call Member Services at **301-468-6000** or toll free at **1-800-777-7902**.

NOTICE OF INSURANCE INFORMATION PRACTICES

ABBREVIATED VERSION

Virginia

Please be advised that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter Kaiser Permanente), has not received any personal information regarding your application from any person other than the applicant. Personal information necessary to determine eligibility for coverage and to make underwriting decisions may be collected from the application, medical questionnaire, and any pre-existing file with Kaiser Permanente. With written authorization by the applicant, any physician, nurse, hospital, clinic, or other provider having treated or attended to the applicant or the applicant's dependents listed on the application, and having possession of any records or information with respect thereto, is authorized to provide such information or records to Kaiser Permanente upon request for the purpose of evaluation of this application. Further, the applicant or individual designated to act on behalf of the applicant is entitled to receive a copy (or photocopy) of this authorization upon request.

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

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

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

60092519 MAS_DC 2013

Important details and notices

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

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

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

12689 (12/1/12–12/31/13)
60092519 MAS_DC 2013

Exclusions and limitations

The following list contains exclusions and limitations associated with the benefits described in the copayment plans and deductible and HSA-qualified deductible plans sections.

Preventive care services

Limitations:

While treatment may be provided in the following situations, the following services are not considered preventive care services. The applicable copayment or coinsurance will apply:

- Monitoring a chronic disease
- Follow-up services after you have been diagnosed with a disease
- Diagnosis of a specific disease when you show signs or have higher than average risk for the disease
- Services when you show signs or symptoms of a specific disease or disease process
- Nonroutine gynecological visits will be charged at the specialty copayment
- Treatment of a medical condition or problem identified during the course of the preventive screening exam, such as removal of a polyp during a sigmoidoscopy

Emergency services

Notification:

If you receive care at a hospital emergency room and/or are admitted to a non–Plan hospital, you, or someone on your behalf, must notify us as soon as possible, not later than 48 hours of any emergency room visit or admission or on the first working day following the emergency room visit or admission, whichever is later, unless it was not reasonably possible to notify us. If admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.

Continuing or follow-up treatment:

We do not cover continuing or follow-up treatment after emergency services unless authorized by Health Plan. We cover only the non–Plan emergency services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our service area or in another Kaiser Foundation Health Plan or allied Plan service area.

Hospital observation:

Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit copayment, if applicable, will not be waived.

Urgent care services

Exclusions:

Urgent care services within our service area that were not provided by a Plan provider or Plan facility.

Limitations:

We do not cover services outside our service area for conditions that, before leaving the service area, you should have known might require services while outside our service area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our service area because of extreme personal emergency.

Ambulance services

Exclusions:

- Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider
- Non-emergency transportation services that are not medically appropriate and that have not been ordered by a Plan provider

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Exclusions and limitations

Vision care

Exclusions:

- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures)
- Eye exercises
- Orthoptic (eye training) therapy
- Sunglasses without corrective lenses unless medically necessary
- Contact lens services other than the initial fitting and purchase of contact lenses as provided in this section
- Noncorrective contact lenses
- Replacement of lost or broken lenses or frames

HSA-qualified deductible (1250, 2500 deductible levels) and deductible (4500, 8000 deductible levels) plan exclusions:

- Exclusions noted above
- Eyeglass lenses and eyeglass frames
- All services related to contact lenses, including examinations, fitting and dispensing, and follow-up visits, except as otherwise noted

Prescription drugs

Exclusions:

- Drugs for which a prescription is not required by law
- Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List
- Drugs obtained from a non–Plan pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered, or associated with a covered authorized referral outside the Service Area
- Take-home drugs received from a hospital, Skilled Nursing Facility, or other similar facility
- Drugs that are not listed in our Preferred Drug List
- Drugs that are considered to be experimental or investigational
- Except as specifically covered under the "Outpatient Prescription Drug Appendix" of your *Membership Agreement*, a drug (a) which can be obtained without a prescription, or (b) for which there is a non–prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug
- Drugs for which the Member is not legally obligated to pay, or for which no charge is made
- Blood or blood products
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss
- Medical foods
- Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program
- Replacement prescriptions necessitated by theft or loss
- Prescribed drugs and accessories that are necessary for Services that are excluded
- Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs
- Alternative formulations or delivery methods that are (a) different from the Health Plan's standard formulation or delivery method for prescription drugs and (b) deemed not Medically Necessary
- Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies

(*continues*)

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Exclusions and limitations *(continued)*

- Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits, including the equipment and supplies associated with the administration of a drug
- Bandages or dressings
- Diabetic equipment and supplies
- Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults
- Immunizations and vaccinations solely for the purpose of travel
- Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee
- Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction
- Over-the-counter contraceptive pills, supplies, and devices

Limitations:

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our preferred drug list and purchased at a Plan pharmacy.
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable cost share per prescription will apply.

Dental services

Exclusions:

The following services are not covered under your dental plan:

- Services provided by dentists or other practitioners of healing arts not associated with the Health Plan and/or dental administrator except upon referral arranged by a participating dental provider and authorized by Health Plan, or when required in a covered emergency
- Services for injuries or conditions that are covered under workers' compensation and/or employer's liability laws
- Services that are provided without cost to members by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid)
- Services that, in the opinion of the attending dentist, are not necessary for the patient's dental health
- Cosmetic or aesthetic dentistry
- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in "Section 3" of the *Membership Agreement*
- Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan as described in "Section 3" of the *Membership Agreement*
- Hospitalization for any dental procedure
- Treatment required for conditions resulting from major disaster, epidemic, or war, including declared or undeclared war or acts of war
- Replacement due to loss or theft of prosthetic appliance
- Services that cannot be performed because of the general health of the patient
- Implantation and related restorative procedures
- Services not listed as covered dental services in the list of covered dental services provided by dental administrator
- Services provided by a nonparticipating dental provider or not preauthorized by dental administrator (with the exception of out-of-area emergency dental services)
- Services related to the treatment of TMD (temporomandibular disorder)

Exclusions and limitations

- Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth
- Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage under this dental plan and agreement. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
- Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan described in the *Membership Agreement*
- Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan as described in the *Membership Agreement*
- Experimental procedures, implantations, or pharmacological regimens

Limitations:

Covered dental services are subject to the following limitations:

- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed
- Replacement of a filling within two (2) years after original date of placement
- Coverage for two (2) periodic oral exams, prophylaxes (cleanings), and fluoride applications is limited to twice per contract year.
- Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's usual, customary, and reasonable (UCR) fee, minus 25 percent.
- Full mouth X-rays or panoramic film is limited to one set every three (3) years.
- Retreatment of root canal within two (2) years of the original treatment
- Coverage for sealants is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
- Coverage for periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
- Coverage for root planing or scaling is limited to once every 24 months per quadrant.
- Full mouth debridement is limited to once every 36 months.
- Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
- Coverage for relining of dentures is limited to once every 12 months.

To request a full list of exclusions and limitations, please call Member Services at 301-468-6000 or 1-800-777-7902 (TTY 301-879-6380), from 7:30 a.m. to 5:30 p.m., Monday through Friday.

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