Better Informed
Better Together

KAISER PERMANENTE® thrive

A better choice for good health

With care and coverage working seamlessly together, Kaiser Permanente is uniquely designed to give you the information and support you need to live healthy.

your choice of top doctors

Our doctors are among the best, and caring for people is their passion. Plus, you've got the power to change doctors anytime.

personalized care and attention

Your doctors, nurses, and specialists are connected to your electronic health record, so they can work together to deliver great care that's right for you.

everything under one roof

You can do more and drive less because many of our locations include pharmacy, lab, X-ray services, and more.

lots of healthy extras

Stay at your best with healthy resources like wellness classes, many of which are no charge.

online access anytime, anywhere

Use your computer, smartphone, or mobile device to email your doctor's office, schedule routine appointments, view lab test results, refill prescriptions, and more.

a better experience

We care about the whole you—body, mind, and spirit. Our doctors, health plans, and medical facilities all work as one, so your experience is smoother and simpler.

kp.org/thrive

Note: Many features discussed in this book are available only to members receiving care at Kaiser Permanente medical facilities.

Better Informed. Better Together.

Welcome to your *Kaiser Permanente for Individuals and Families Enrollment Guide*. This guide will help you understand what health care means for you and how to select the right health plan for your needs. Read on to learn why Kaiser Permanente is the best choice for you and your family.

Important deadline

Open enrollment ends **March 31, 2014**. See page 12 for details, and learn about special situations that may allow you to submit your application for health coverage after this date.

What's inside

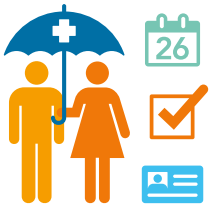
Why health care matters

Health care coverage makes it easier to get the care you need to get healthy and stay healthy. There are two parts of health care. One part involves the team (doctors, nurses, specialists) that provides care and the facilities where you receive care. The other part is the coverage you need to pay for that care. At Kaiser Permanente, we offer both parts in one convenient package.

Health care

Almost everyone gets sick or hurt, or needs some kind of medical help. To get better, you usually need care—like seeing a doctor, staying in a hospital, taking medication, or all of the above. Health care includes many important services, such as:

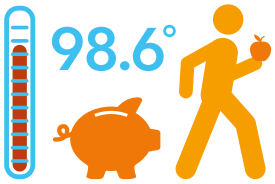
- doctors' office visits
- hospital stays
- emergency room visits
- X-rays
- laboratory tests
- prescription drugs
- preventive care
  - well-baby exams (under 24 months)
  - well-woman visits
  - general immunizations
  - screenings
  - no-charge prenatal exams
  - vision exams



Health coverage

Health coverage is a lot like the coverage people have to protect their car or home. Some people get health coverage through their jobs, and some buy it themselves. Without coverage, high medical bills can wipe out savings and even lead to bankruptcy. Health coverage helps protect you financially if you have a serious illness or injury that requires extensive care.

- Each month, you pay a premium—your monthly rate—to your insurance health plan for your health care coverage. If you qualify for federal financial assistance, you might get help paying this premium. The federal government would pay any financial assistance to Kaiser Permanente on your behalf. See page 4 to learn more.
- When you need care (such as doctor visits, hospital care, and medications), your health plan may help you pay for it.



How you benefit

Here are some of the major advantages of having health care coverage:

- **Peace of mind.** You shouldn't have to worry about how you're going to pay if you get sick, injured, or pregnant. Life is unpredictable, but when you have health coverage, you have more control, and you can rest easy knowing that you're going to get the care you need.
- **Care when you need it.** You can see a doctor when you're sick or just need preventive care. You don't need to ignore symptoms or hope they'll go away. You can get treated before things get worse.
- **Stay on a healthy path.** Preventive care helps you catch minor symptoms before they become problems. Screenings, like mammograms and cholesterol level tests, can catch problems early—when they're easier to treat.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

What health care reform means for you

On March 23, 2010, the Affordable Care Act (ACA)—also known as health care reform—became federal law. Many of the changes resulting from the law mean more peace of mind for you and your family.

If you have health coverage now, you're probably already enjoying some of the benefits of health care reform, including more preventive care for no charge and being able to keep your children on your plan until they turn 26. If this is your first time shopping for health coverage, or you're switching plans, you'll be getting all of these benefits and more with your new 2014 plan.

Everyone can enroll

Effective January 1, 2014, anyone can get coverage. You can no longer be denied coverage because of a medical condition, and you don't have to pass a medical exam to qualify for coverage.

Stay up-to-date with ACA requirements

All of our plans can help you meet the requirement that most U.S. citizens and legal residents have a basic level of health coverage starting January 1, 2014. In most cases, if you don't buy coverage and go without it for three consecutive months or longer, you'll be charged a tax penalty by the government.

Some people don't have to buy health coverage. For example, if your income is below a certain level or you have certain religious beliefs, you may not have to purchase coverage. In such cases, you may be able to file for an exemption at the Health Insurance Marketplace.

Marketplaces are open

You can buy your Kaiser Permanente plan directly from us and the Health Insurance Marketplace. Marketplaces are federal or state-run markets where you can shop, compare, and buy health care coverage. In Maryland, the Marketplace is called Maryland Health Connection.

The choice is yours

When shopping at the Marketplace for a Kaiser Permanente plan, you'll see three levels of coverage—Bronze, Silver, and Gold. You can choose the plan that best meets your needs.

- All plans will offer the same essential health benefits (such as doctor visits, hospital care, prescriptions, and maternity care) and will include certain preventive services for no charge.
- The main difference is how you pay for care. Our Bronze plans generally offer lower premiums but higher out-of-pocket costs. Gold plans generally have higher premiums and lower out-of-pocket costs.
- There's an additional Catastrophic plan, a high-deductible plan option for applicants under age 30. Applicants age 30 and older may also purchase this plan only if they provide evidence of eligibility for each person, in the form required by Kaiser Permanente, demonstrating a lack of affordable coverage or financial hardship. The Catastrophic plan has the same basic benefits as the Bronze, Silver, and Gold plans. But it has lower premiums and higher out-of-pocket costs (including a higher deductible than the other deductible plans). However, the Catastrophic plan offers a total of three office visits for certain services as well as preventive care services for no charge before the deductible.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Do you qualify for financial assistance?

If you need help paying for health care, you may qualify for financial assistance. Under health care reform, the federal government will provide financial assistance for people with qualifying incomes. Here's some information to help you find out whether you may be eligible.

Federal financial assistance available

Starting in October 2013, you'll be able to apply for financial assistance from the federal government to help pay for care and coverage under Kaiser Permanente's new 2014 plans.

- Help with premiums and out-of-pocket expenses (deductibles, copayments, coinsurance) will be available only if you buy your new 2014 Kaiser Permanente coverage through your Health Insurance Marketplace, Maryland Health Connection, at marylandhealthconnection.gov.
- If you qualify, the federal government will pay Kaiser Permanente any financial assistance on your behalf.
- Assistance will be on a sliding scale, based on modified adjusted gross income and family size.

Are you eligible for assistance?

There are a few ways to find out:

- Use this chart to get an idea of whether you and your family may qualify:

Number of people in household	2013 annual family income levels to qualify[1]
1	$45,960 or below
2	$62,040 or below
3	$78,120 or below
4	$94,200 or below
5	$110,280 or below
6	$126,360 or below
7	$142,440 or below
8	$158,520 or below

[1]2013 modified adjusted gross income levels are the latest available; assistance will be based on estimated 2014 modified adjusted gross income. Results are subject to confirmation by Maryland Health Connection.

- Use Kaiser Permanente's online calculator at **buykp.org**. You'll get an estimate of how much assistance you may receive to help pay your premium.

What should you do next?

Go to Maryland Health Connection for a determination of your total financial assistance eligibility for your premium and out-of-pocket expenses. You'll also be able to enroll in a new 2014 Kaiser Permanente plan through marylandhealthconnection.gov if you qualify for assistance.

Please note that if you have the option of receiving health coverage through your employer, you may not be eligible for financial assistance.

What if you don't qualify for assistance?

You have two choices:

- You can still purchase a 2014 Kaiser Permanente plan through Maryland Health Connection.
- Or you can purchase your coverage directly from us—that's easiest.

Either way, your plan will offer the same benefits and services.

Have questions?

We've got answers. We'll help you decide which Kaiser Permanente plan is best for you, even if you apply through marylandhealthconnection.gov. Call us at **1-800-494-5314**, or contact your agent or broker.

You can also review the "Choosing the right plan for you" section on page 14 and the "Health plan benefit highlights" chart starting on page 18 for helpful details on your health care coverage options. For information on when and how to enroll, see page 12.

Your partner for better health

Making smart decisions about your health may be easier than you think, whether you're looking for a new plan or choosing health coverage for the first time. Take a look at all you get with your membership, and you'll see how Kaiser Permanente can help you live a healthier life.

The power to choose

Make the best choice for you and your family. With many great doctors and convenient facilities to choose from, it's easier to get the care you need when you need it.

Excellent care

Your electronic health record informs your care team at Kaiser Permanente facilities and enables their teamwork. This way you're treated as a person, not a symptom.

Online access anytime, anywhere

Stay better informed about your health—and better able to manage it—with online and mobile tools that help you get the support you need.

Convenient classes, resources, and more

Take your health beyond checkups with a partner that provides the inspiration and information you need to live life to the fullest.

Everything at your fingertips

Make life easier. Our online and mobile resources can help you to pick the right plan, find locations near you, and get the most out of your coverage.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

The power to choose

Stay in charge of your health. It's simple to make the right choice when you've got great doctors, convenient facilities, and care when you need it.

Your choice of skilled doctors

We've carefully selected our doctors so you can make the right choice for you and your family. Many of our highly respected doctors come from the top medical schools in the country. And it's easy to take your pick—just go online to view our doctor profiles. You can choose or change your doctor anytime.

Under-one-roof convenience

Save time and avoid driving all over town for care. You have many locations to choose from, and most of them offer multiple services under one roof. You can see your doctor, get a lab test or an X-ray, and pick up your medications—all without leaving the building. And when you get care with fewer delays, you can get better faster.

What you need, when you need it

- Email your doctor's office with nonurgent questions.
- Refill most prescriptions online with shipping at no charge.
- Make routine appointments with a call or click.
- View recent office visits and most test results online.
- Get same-day, after-hours, and weekend services at many locations.
- Call for advice from a registered nurse, 24 hours a day.
- Travel freely; you're covered for emergency care worldwide.

See how Kaiser Permanente has helped members at **kp.org/carestories**.

Your electronic health record brings it all together

Your doctor's office

Your record gets updated with each visit to our Kaiser Permanente facilities, so it's always current.

Pharmacy, lab, X-ray

No need for paperwork when you get services at our facilities—your doctor's orders are already there.

Note: Many features discussed in this guide are available only to members receiving care at Kaiser Permanente medical facilities.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Excellent care

Teamwork and expertise combined help make our doctors, nurses, and specialists better informed to provide the best care for your needs.

Personalized care and attention

A care team that's informed and focused on you can lead to better health. Supported by your secure electronic health record, your doctors, nurses, and specialists are better prepared to deliver the right care at the right time—even if you go to different Kaiser Permanente locations in your area.

Easy access to specialty care

Our specialists are connected to real-time updates on your electronic health record, so they can diagnose and treat conditions more efficiently. And because they work closely with your doctor, referrals are easier. You can email your doctor's office to request a referral, and once you get it, see any available specialist of your choice.

A focus on you and your family

With medical care and health coverage working together, there are fewer administrative hassles for you and your care team. You're empowered to get the care you need, and your doctors, nurses, and specialists can focus on what they do best. With caring, compassion, and a love for what they do, your team is united by one shared goal—to help you get well and stay well.

Learn more about the doctors available in your area at **kp.org/doctorsandlocations**.

Specialty care

Your specialists are up to speed and ready to take care of you.

At home or on the go

Get your health information on your computer or mobile device to stay informed and in charge.

Note: Many features discussed in this guide are available only to members receiving care at Kaiser Permanente medical facilities.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Online access anytime, anywhere

At home or on the go, we've got you covered. Plug into your health with our online and mobile tools that help you get what you want, when you want it.

It's easy to stay connected

Members registered on **kp.org** have secure access to My Health Manager, the online tool that helps you manage your care at our facilities.

- Email your doctor's office.
- Refill most prescriptions.
- View most lab test results.
- Schedule or cancel routine appointments.
- Care for a family member using these features.

A website full of healthy ideas

Get informed and inspired on our award-winning website, **kp.org**. Take charge of your health with articles, wellness topics, and health calculators. Our music channels, podcasts, fitness videos, and recipes from world-class chefs can help you find new ways to live well.

Good health on the go

Manage your care at home, work, or play with our mobile app. It puts all the convenient features of My Health Manager right in the palm of your hand. You can download the Kaiser Permanente app from the App Store℠ or Google Play®.

App Store is a service mark of Apple, Inc., and Google Play is a trademark of Google, Inc.

For a guided tour of My Health Manager, visit **kp.org/experience**.

Top reasons to join Kaiser Permanente

Better care

A care team that's coordinated and focused on you.

Better doctors

Choose from skilled doctors who are in it because they care.

Note: Many features discussed in this guide are available only to members receiving care at Kaiser Permanente medical facilities.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Convenient classes, resources, and more

We have a passion for prevention. That's why we give you lots of healthy extras that can help you stay informed about ways to live healthier in body, mind, and spirit.

Learn something new

Fit wellness into your schedule, no matter how busy you are. With the many health classes offered at our facilities, there's something for everyone. Try classes on yoga, eating well, baby care, specific health conditions, and much more. Classes vary by location and some may require a fee.

Strive to thrive: Wellness Coaching by Phone

Get help making positive changes with your own personal wellness coach. Our experienced and licensed coaches are available to members by phone, at no charge. Your coach will work one-on-one with you to help you set goals to improve your health, and get tools, resources, and personalized support to achieve them.

Maximize your health

Our personalized online wellness programs can help you lose weight, stay active, reduce stress, sleep better, stop smoking, and much more. You can also download the Every Body Walk! app for your smartphone or mobile device from the App Store or Google Play. It's a fun, interactive tool to help you create and maintain a daily walking routine.

Find tools, tips, and information for living well at **kp.org/livehealthy**.

Better access

Email your doctor's office, call for advice, and get appointments when you need them.

Better visits

Doctor, lab, X-rays, and pharmacy all in one place at most of our locations.

Watch members share why they chose Kaiser Permanente at **kp.org/thrive**.

Note: Many features discussed in this guide are available only to members receiving care at Kaiser Permanente medical facilities.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Everything at your fingertips

We know you have a busy schedule. That's why we do everything we can to make things simpler for you—whether you're enrolling in a health plan or looking for a medical facility to get care.

Online enrollment

You'll find the *Application for Health Coverage* included with this guide. But for the fastest response, enroll online today at **buykp.org/apply**. If you're working with an agent or broker, use the personalized link he or she has provided.

Checking for financial help

Federal financial assistance to help pay for health coverage is available for those who qualify. If you qualify for assistance and purchase a Kaiser Permanente plan through Maryland Health Connection, the federal government will pay any financial assistance directly to Kaiser Permanente on your behalf. Use our online calculator at **buykp.org** to get an estimate of how much assistance you may receive to help pay your premium. Final determination about financial assistance will be made by Maryland Health Connection.

Location, location, location

It's easy to find the care you need, when you need it. Many Kaiser Permanente facilities are located in your area. Visit **buykp.org/facilities** to find one near your home or office. You can even search our locations when you're on the go. Just download our Kaiser Permanente app for your smartphone or mobile device from the App Store or Google Play—then use the location finder.

Search for a facility by ZIP code or keywords at **buykp.org/facilities**.

We're always here to help

Call us

Call **1-800-494-5314** to speak with one of our representatives who will be happy to help you understand your options and pick the right Kaiser Permanente health plan for you.

Go online

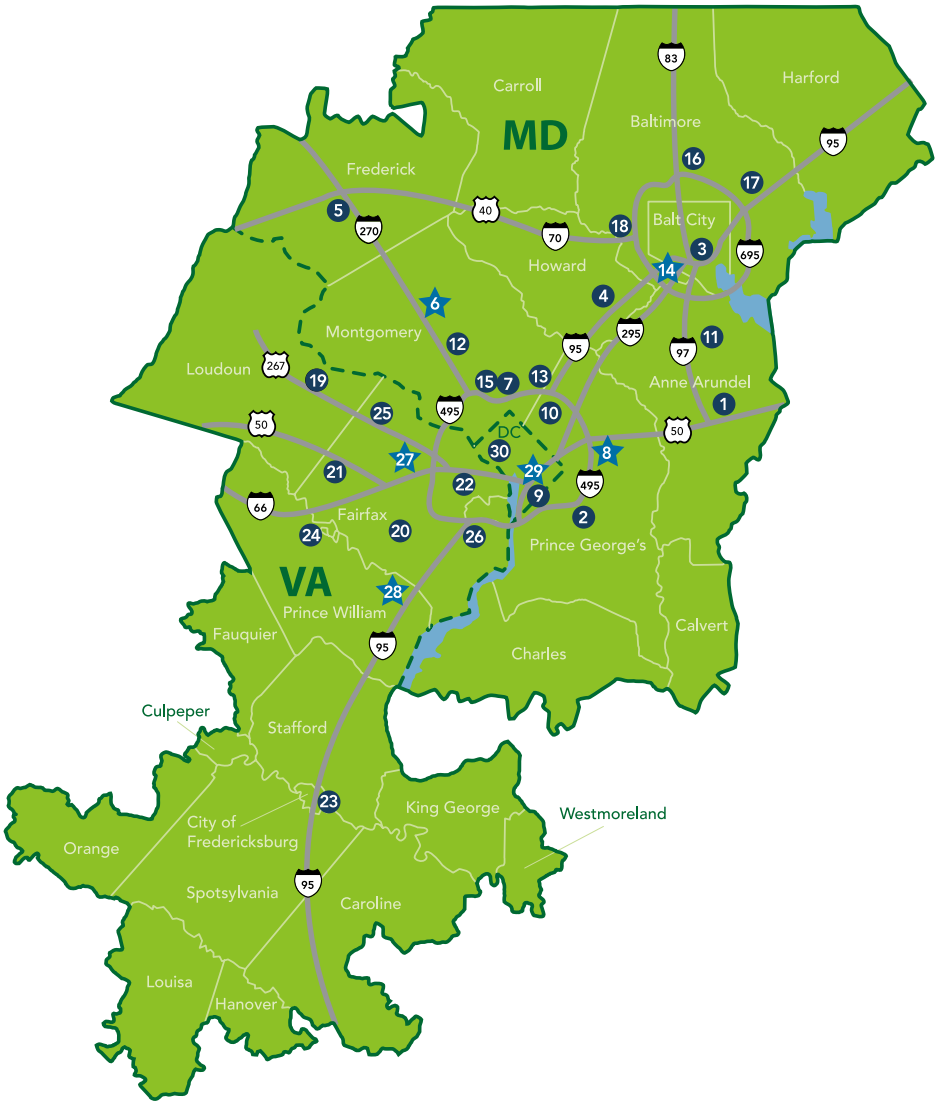
Ready to purchase a Kaiser Permanente plan? Visit **buykp.org/apply** to get started, or contact your agent or broker.

Note: Many features discussed in this guide are available only to members receiving care at Kaiser Permanente medical facilities.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Find a facility near you

Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. We have a number of facilities in your area. Please refer to the map below to find the one nearest you.



Kaiser Permanente medical facilities

Maryland

1 Annapolis Medical Center
2 Camp Springs Medical Center
3 City Plaza Medical Center
4 Columbia Gateway Medical Center
5 Kaiser Permanente Frederick Medical Center
6 Gaithersburg Medical Center
7 Kensington Medical Center
8 **EXPANDED** Largo Medical Center
9 Marlow Heights Medical Center
10 Prince George's Medical Center
11 Severna Park Medical Center
12 Shady Grove Medical Center
13 Silver Spring Medical Center
14 **NEW** South Baltimore County Medical Center
15 Summit Behavioral Health Center
16 Towson Medical Center
17 White Marsh Medical Center
18 Woodlawn Medical Center

Virginia

19 Ashburn Medical Center
20 Burke Medical Center
21 Fair Oaks Medical Center
22 Falls Church Medical Center
23 Kaiser Permanente Fredericksburg Medical Center†
24 Manassas Medical Center
25 Reston Medical Center
26 Springfield Medical Center
27 Tysons Corner Medical Center
28 Woodbridge Medical Center

Washington, D.C.

29 Kaiser Permanente Capitol Hill Medical Center
30 Northwest D.C. Medical Office Building

★ These centers offer **24/7**:
- Urgent care
- Lab
- Pharmacy
- Radiology

†Not available for Medicare Plus enrollees

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

When to enroll in your plan

Once you understand why you need health care coverage and whether you qualify for financial assistance, the next step is knowing when and how to enroll. Here's an overview of what you need to do to get the plan of your choice.

Open enrollment

There's a deadline to apply for health care coverage. You can apply starting October 1, 2013, through March 31, 2014. This is called the open enrollment period. It's when you can enroll in health plans through Maryland Health Connection or directly through Kaiser Permanente.

To enroll during this 2014 open enrollment period, you must make sure we receive your completed *Application for Health Coverage* – along with your first month's premium – no later than March 31, 2014.

Special enrollment

After open enrollment, you can still enroll during special enrollment periods in the case of certain events that change your status. Special enrollment periods last 60 days after any of these events, which may include the following:

- marriage
- birth or adoption of a child
- divorce
- loss of job and employer-sponsored coverage
- termination of existing coverage

Please include proof of your special event with your application.

Open enrollment period – October 1, 2013 through March 31, 2014

If you want your coverage to start on:	Your completed application and first month's premium must be received by:
January 1, 2014	October 1, 2013 – December 15, 2013
February 1, 2014	December 16, 2013 – January 15, 2014
March 1, 2014	January 16, 2014 – February 15, 2014
April 1, 2014	February 16, 2014 – March 15, 2014
May 1, 2014	March 16, 2014 – March 31, 2014

Special enrollment period – April 1, 2014 through November 15, 2014

Enrolling outside open enrollment due to a life-changing event

If you want your coverage to start on:	Your completed application, first month's premium, and proof of special event must be received by:
May 1, 2014	April 1, 2014 – April 15, 2014
June 1, 2014	April 16, 2014 – May 15, 2014
July 1, 2014	May 16, 2014 – June 15, 2014
August 1, 2014	June 16, 2014 – July 15, 2014
September 1, 2014	July 16, 2014 – August 15, 2014
October 1, 2014	August 16, 2014 – September 15, 2014
November 1, 2014	September 16, 2014 – October 15, 2014
December 1, 2014	October 16, 2014 – November 15, 2014

For more detailed information on your specific special event, please call **1-800-494-5314**.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Simple steps to enroll

1. Choose a plan

Pick the plan that's right for you. You can cover your entire family under the same plan or separate plans.

2. Confirm your rate area

Check the "Health plan rates" section on page 21 of this guide to see whether your home ZIP code is listed. If it isn't, call us at **1-800-494-5314**, or contact your agent or broker.

3. See if you're eligible for financial assistance

You may be eligible for financial assistance from the federal government for your 2014 Kaiser Permanente health plan. If you qualify, the federal government will pay any financial assistance to Kaiser Permanente on your behalf. Help may be available for:

- monthly premiums
- out-of-pocket costs, such as copayments, coinsurance, or deductibles

See the "Do you qualify for financial assistance?" section of this guide on page 4 for more information. If you're eligible, you must purchase your Kaiser Permanente plan through Maryland Health Connection to get assistance. If you're not eligible, continue to step 4.

4. Complete your application

Complete an online application at **buykp.org/apply** or use a paper application. If you're working with an agent or broker, be sure to complete that section of the application.

5. Select your payment method

Payment for your first month's coverage by check, money order, debit card, or credit card is required with your application.

6. Sign the application form

Please make sure you've signed everywhere indicated on the application. If your application is missing any information, signatures, documentation, or payment, this may delay your effective date or cancel your application.

7. Submit the application form with payment and all necessary documentation

- **Online:** For the fastest response, enroll online today at **buykp.org/apply**. Or if you're working with an agent or broker, use the personalized link he or she has provided.
- **Fax: 301-388-1615**
- **Mail:** Membership Administration Dept./KPIF 5W
  Kaiser Permanente
  2101 East Jefferson St., Suite 100
  Rockville, MD 20852–9995

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Choosing the right plan for you

Before you buy your plan—whether directly from us or through Maryland Health Connection—we can help you decide which Kaiser Permanente plan is best for you. That way, you'll know which plan to select as you complete your enrollment. Here's some important information to help you make your decision.

Health plan types

Learn about our plans, and see examples of how they work. They all offer the same basic health benefits, along with quality care and support. No matter which plan you select, you get top doctors and a care team focused on you—all working together with the latest technology to offer well-coordinated, personalized care.

Comparing health plans

Get an overview of what you might pay for services under different plans, and get a sense of which one best meets your needs.

Health plan benefit highlights

Compare plans and benefits.

Dental plans

Our health plans include pediatric dental benefits for anyone 18 and younger. For adults 19 and older, preventive dental is included in our plans.

Health plan rates

Fill out our rate worksheet so you can determine your monthly rate.

Health plan types

With each level of coverage—Bronze, Silver, or Gold—there are different types of plans that work in different ways, depending on how you want to pay for services. You can choose one plan for your entire family or separate plans for different family members. If your family members choose different plans, each plan will have a separate deductible and out-of-pocket maximum.

Copayment plans

Copayment plans have set fees for most covered services and no medical deductibles.

- With copayments, you know in advance how much you'll pay for things like doctor's office visits or prescriptions.

Our copayment plan

KP MD Gold 0/20/Dental/PedDental

How it works

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 the KP MD Gold 0/20/Dental/PedDental copayment plan, you would pay a separate copayment for each of the covered services you received. You do not have to reach a deductible.

- In this case, you would pay a $20 copay for the doctor's office visit, a $20 copay for the X-ray, and a $10 copay for the generic drug.
- Your copays would contribute to your out-of-pocket maximum.

Please note this is only an example of how a copayment plan works. See the "Health plan benefit highlights" chart starting on page 18 for more detailed information.

Deductible plans

Deductible plans have lower monthly rates. If you need care, you'll usually pay full charge for most covered services until you reach a set amount known as your *deductible*.

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 individual out-of-pocket maximum before the family out-of-pocket maximum is met.

- Once you've reached your deductible, you'll pay a copayment or coinsurance for most covered services for the rest of the contract year.
- Most preventive care services will be covered at no charge even before you reach your deductible.

Our deductible plans

KP MD Gold 1000/20/Dental/PedDental
KP MD Silver 1500/30/Dental/PedDental
KP MD Silver 2500/30/Dental/PedDental
KP MD Bronze 4500/50/Dental/PedDental
KP MD Catastrophic 6350/0/Dental/PedDental

How it works

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 MD Silver 1500/30/Dental/PedDental deductible plan, you would have to pay $1,500 out of your own pocket before being eligible to pay only a copay or coinsurance for certain covered services. However, our two Silver deductible plans offer generic drugs, X-rays, and office visits for certain services for a copay before the deductible is met.

- In this example, the doctor's office visit, the X-ray, and the prescription are available for a copay before you reach your deductible. You would pay just a $30 copay for the doctor's office visit, $30 copay for the X-ray, and a $15 copay for the generic drug.

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- Your copays would contribute toward your out-of-pocket maximum but not toward your deductible.

Please note this is only an example of how a deductible plan works. See the "Health plan benefit highlights" chart starting on page 18 for more detailed information.

HSA-qualified deductible plans

With HSA-qualified deductible plans, you can open a health savings account (HSA) that allows you to pay for qualified medical expenses with tax-deductible or pre-tax dollars.

- You can contribute tax-deductible or pre-tax dollars into an HSA (health savings account), and use this money to help pay for eligible medical expenses, such as copayments, coinsurance, and deductible payments for services covered under your health plan. You can also use your HSA dollars for services that may not be covered under your health plan, such as eyeglasses and laser eye surgery, dental care, acupuncture, and chiropractic services. For a complete list of qualified medical expenses, see Publication 502, Medical and Dental Expenses, at irs.gov.
- Tax references relate to federal income tax only. For more information, consult your financial or tax adviser. To learn more about health savings accounts, visit irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

Our HSA-qualified plans

KP MD Silver 1750/25%/HSA/Dental/PedDental
KP MD Bronze 4500/50/HSA/Dental/PedDental
KP MD Bronze 5000/30%/HSA/Dental/PedDental

How it works

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 the KP MD Bronze 4500/50/HSA/Dental/PedDental plan, you would pay full charge for most covered services until you reach your $4,500 deductible. However, if you open and fund an HSA, you can pay for your deductible, copays, and coinsurance with tax-deductible or pre-tax dollars. Most preventive care services would be covered at no charge even before the deductible is met.

- In the situation above, you would pay the first $4,500 of your medical and pharmacy expenses out of your own pocket. However, if you have money available in your HSA, you can be reimbursed from your health savings account. After meeting the $4,500 deductible, you would start paying only a copay or coinsurance for most covered services.
- If you haven't reached your deductible, you would pay full charge for the doctor's office visit, the X-ray, and the medication. If you've already reached your deductible, you would pay only a $50 copay for the doctor's office visit, a $50 copay for the X-ray, and a $20 copay for the generic drug.
- All the charges you pay for covered services including all copays, coinsurance, and deductible payments would apply to your out-of-pocket maximum.

Please note this is only an example of how an HSA-qualified plan works. See the "Health plan benefit highlights" chart starting on page 18 for more detailed information.

The HSA-qualified deductible plan difference for family plans

Deductibles and out-of-pocket maximums work differently in our traditional deductible plans versus our HSA-qualified deductible plans for family coverage.

Under our HSA-qualified deductible family plans, there is no individual member deductible or out-of-pocket maximum. Instead, all plans have a family deductible and an out-of-pocket maximum, which can be met by the expenses of one or more family members toward a combined family deductible and out-of-pocket maximum. Once the combined expenses of all covered family members reach the applicable deductible or out-of-pocket maximum, the deductible or out-of-pocket maximum will be considered satisfied for all family members for the remainder of the contract year.

A focus on prevention

Preventive screenings help keep you healthy by providing an early alert for many health conditions. That way, they can be treated before they become serious. Under health care reform, many are available at no charge—even if you have a deductible plan.

Here are some examples of preventive care services:

- routine preventive physical exams
- well-child exams (under 24 months)
- well-woman visits
- general immunizations
- annual flu shots
- routine preventive laboratory tests
- flexible sigmoidoscopies and colonoscopies
- mammogram screenings
- contraceptive care and counseling
- breastfeeding support

For a complete list of our preventive care services, visit **kp.org/prevention**.

Comparing health plans

See the "Health plan benefit highlights" chart starting on the next page for an overview of what you can expect to pay for services under our plans. This will help you understand which one best meets your needs. For traditional deductible plans, keep in mind that most of the amounts shown apply only after you reach your deductible. To get an idea of what you might pay before reaching your deductible, check out our resources at **kp.org/treatmentestimates**.

Here's a quick look at how to use the chart.

	KP MD Silver 1500/30/Dental/PedDental
Plan type	Deductible
Features	
Individual plan annual deductible (subscriber only)	$1,500
Family plan annual deductible (individual/family)	$1,500/$3,000
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350
Family plan annual out-of-pocket maximum (individual/family)	$6,350/$12,700
Benefits	
Preventive care	
Routine physical exam	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$30
Specialty care office visit	$50
Most X-rays	$30
Most lab tests	$30
MRI, CT, PET	$250
Outpatient surgery	30% after deductible
Mental health visit	$30
Inpatient hospital care (per admission)	
Room and board, surgery, anesthesia, X-rays, lab tests, medications	30% after deductible
Maternity	
Routine prenatal care visit	No charge
Delivery and inpatient well-baby care	30% after deductible
Emergency and urgent care	
Emergency Department visit	$350
Urgent care visit	$50
Prescription drugs	
Plan pharmacy (up to a 30-day supply)	Generic: $15 Preferred brand: $45 After $250 preferred brand deductible per member
Mail order (up to a 90-day supply)	Generic: $30 Preferred brand: $90 After $250 preferred brand deductible per member

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charge for most services until you reach $1,500 for yourself or $3,000 for your family. Then you'd start paying copayments (copays) or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during a policy period (usually a year) before your plan starts paying 100 percent for most covered services. In this example, you'd never pay more than $6,350 for yourself and no more than $12,700 for your family for your deductible, copayments, and coinsurance in a contract year.

Preventive care at no charge

Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they're not subject to the deductible.

Not subject to the deductible

Some services are always covered at a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a $30 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits are not subject to the deductible.

Coinsurance

After reaching your deductible, you may start paying a percentage of the total cost for certain services. Here, you'd pay 30 percent of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the contract year.

Copayment

This is the set amount you pay for certain services, usually after you reach your deductible. In this example, you'd start paying a $350 copay for Emergency Department visits whether or not you have met your deductible.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Health plan benefit highlights

The plans and benefits offered in this guide are Off Exchange, and can only be purchased directly through Kaiser Permanente.

	KP MD Bronze 5000/30%/HSA/ Dental/PedDental	KP MD Bronze 4500/50/HSA/ Dental/PedDental	KP MD Bronze 4500/50/ Dental/PedDental	KP MD Silver 1750/25%/HSA/ Dental/PedDental	KP MD Silver 2500/30/ Dental/PedDental
Plan type	HSA-qualified	HSA-qualified	Deductible	HSA-qualified	Deductible
Features					
Individual plan annual deductible (subscriber only)	$5,000	$4,500	$4,500	$1,750	$2,500
Family plan annual deductible (individual/family)	$10,000/$10,000	$9,000/$9,000	$4,500/$9,000	$3,500/$3,500	$2,500/$5,000
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350	$6,350	$6,350	$5,000	$6,350
Family plan annual out-of-pocket maximum (individual/family)	$12,700/$12,700	$12,700/$12,700	$6,350/$12,700	$10,000/$10,000	$6,350/$12,700
Benefits					
Preventive care					
Routine physical exam	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	30% after deductible	$50 after deductible	$50	25% after deductible	$30
Specialty care office visit	30% after deductible	$50 after deductible	$50	25% after deductible	$50
Most X-rays	30% after deductible	$50 after deductible	$50 after deductible	25% after deductible	$30
Most lab tests	30% after deductible	$50 after deductible	$50 after deductible	25% after deductible	$30
MRI, CT, PET	30% after deductible	$500 after deductible	$500 after deductible	25% after deductible	$300
Outpatient surgery	30% after deductible	30% after deductible	20% after deductible	25% after deductible	30% after deductible
Mental health visit	30% after deductible	$50 after deductible	$50	25% after deductible	$30
Inpatient hospital care (per admission)					
Room and board, surgery, anesthesia, X-rays, lab tests, medications	30% after deductible	$500 per day up to 4 days after deductible[1]	20% after deductible	25% after deductible	30% after deductible
Maternity					
Routine prenatal care visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	30% after deductible	20% after deductible	25% after deductible	30% after deductible
Emergency and urgent care					
Emergency Department visit	30% after deductible	$500 after deductible	20% after deductible	25% after deductible	$400
Urgent care visit	30% after deductible	$50 after deductible	$50	25% after deductible	$50
Prescription drugs					
Plan pharmacy (up to a 30-day supply)	Generic: $20 Preferred brand: 30% All after deductible	Generic: $20 Preferred brand: $50 All after deductible	Generic: $25 Preferred brand: 50% After $500 preferred brand deductible per member	Generic: $15 Preferred brand: $45 All after deductible	Generic: $15 Preferred brand: $45 After $250 preferred brand deductible per member
Mail order (up to a 90-day supply)	Generic: $40 Preferred brand: 30% All after deductible	Generic: $40 Preferred brand: $100 All after deductible	Generic: $50 Preferred brand: 50% After $500 preferred brand deductible per member	Generic: $30 Preferred brand: $90 All after deductible	Generic: $30 Preferred brand: $90 After $250 preferred brand deductible per member

This is a summary of the most frequently asked-about benefits and their copayments, coinsurance, and deductibles. Please refer to the *Membership Agreement* for detailed information about your plan (*form KFHP-NG-KPIF-MD*), which will be mailed to you upon enrollment or upon request. To request a copy of the *Membership Agreement* for a particular plan, please call us at 1-800-634-4579 or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For a list of exclusions and limitations for the benefits shown, please see the "Exclusions and Limitations" section.

[1]After 4 days, there is no charge for covered services related to this admission.

Health plan benefit highlights

The plans and benefits offered in this guide are Off Exchange, and can only be purchased directly through Kaiser Permanente.

	KP MD Silver 1500/30/Dental/PedDental	KP MD Gold 1000/20/Dental/PedDental	KP MD Gold 0/20/Dental/PedDental	KP MD Catastrophic 6350/0/Dental/PedDental[2]
Plan type	Deductible	Deductible	Copayment	Deductible
Features				
Individual plan annual deductible (subscriber only)	$1,500	$1,000	None	$6,350
Family plan annual deductible (individual/family)	$1,500/$3,000	$1,000/$2,000	None/None	$6,350/$12,700
Individual plan annual out-of-pocket maximum (subscriber only)	$6,350	$6,350	$6,350	$6,350
Family plan annual out-of-pocket maximum (individual/family)	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700
Benefits				
Preventive care				
Routine physical exam	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$30	$20	$20	First 3 office visits no charge.[3] Additional visits no charge after deductible.
Specialty care office visit	$50	$40	$40	No charge after deductible
Most X-rays	$30	$20	$20	No charge after deductible
Most lab tests	$30	$20	$20	No charge after deductible
MRI, CT, PET	$250	$150	$250	No charge after deductible
Outpatient surgery	30% after deductible	20% after deductible	30%	No charge after deductible
Mental health visit	$30	$20	$20	First 3 office visits no charge.[3] Additional visits no charge after deductible.
Inpatient hospital care (per admission)				
Room and board, surgery, anesthesia, X-rays, lab tests, medications	30% after deductible	20% after deductible	$500 per day up to 4 days[1]	No charge after deductible
Maternity				
Routine prenatal care visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	$500 per day up to 4 days[1]	No charge after deductible
Emergency and urgent care				
Emergency Department visit	$350	$250	$250	No charge after deductible
Urgent care visit	$50	$40	$40	No charge after deductible
Prescription drugs				
Plan pharmacy (up to a 30-day supply)	Generic: $15 Preferred brand: $45 After $250 preferred brand deductible per member	Generic: $10 Preferred brand: $30	Generic: $10 Preferred brand: $30	No charge after deductible
Mail order (up to a 90-day supply)	Generic: $30 Preferred brand: $90 After $250 preferred brand deductible per member	Generic: $20 Preferred brand: $60	Generic: $20 Preferred brand: $60	No charge after deductible

This is a summary of the most frequently asked-about benefits and their copayments, coinsurance, and deductibles. Please refer to the *Membership Agreement* for detailed information about your plan (*form KFHP-NG-KPIF-MD*), which will be mailed to you upon enrollment or upon request. To request a copy of the *Membership Agreement* for a particular plan, please call us at 1-800-634-4579 or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. For a list of exclusions and limitations for the benefits shown, please see the "Exclusions and Limitations" section.

[1]After 4 days, there is no charge for covered services related to this admission.
[2]Only applicants under age 30, or applicants age 30 and older who provide evidence of eligibility, in the form required by Kaiser Permanente, demonstrating a lack of affordable coverage or financial hardship, may purchase a KP MD Catastrophic 6350/0/Dental/PedDental plan.
[3]The KP MD Catastrophic 6350/0/Dental/PedDental plan includes three office visits at no charge before you reach your deductible. Office visits include primary or outpatient mental health care.

Have questions? Call us at **1-800-494-5314**. • Go to **buykp.org/apply**. • Or contact your agent or broker.

Dental plans

We emphasize healthy smiles through preventive care. Kaiser Permanente health plans provide essential health benefits including pediatric dental benefits for those age 18 and younger, in addition to a Preventive Dental Plan for adults age 19 and older. Dental benefits are administered through Dominion Dental Services USA, Inc. (Dominion), and promote healthy teeth and gums to help reduce the need for costly procedures in the future.

A reason to smile

In the Preventive Dental Plan, adults 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.

Pediatric dental[1]

For the new 2014 plans, Kaiser Permanente health plans provide essential health benefits including pediatric dental benefits for those age 18 and younger. By enrolling in a 2014 plan, you will be automatically enrolled with Dominion Dental for pediatric dental benefits. **In order to utilize your pediatric dental benefits, you must first select a Dominion dentist for your care. To select a participating dentist, please go online at DominionDental.com/find-a-dentist or call Dominion Dental Member Service Department at 1-888-518-5338.**

For more information, call our Member Service Contact Center at **301-468-6000** or **1-800-777-7902**.

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**.)

[1]Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic (Kaiser Permanente) and administered by Dominion Dental Services USA, Inc. (Dominion).

Health plan rates

We're here to help you find the best plan for your needs. Use the following rate chart and plan cost worksheet on page 22 to help you evaluate your plan options.

What determines your rate?

Your rate is based on the following:

- the plan you select
- where you live, based on your ZIP code
- your age at the time of your effective date
- whether you use tobacco

If you move and change your home ZIP code, your monthly rate may change. If you move to a ZIP code that isn't covered by Kaiser Permanente, your coverage may not continue.

Rates are determined individually based on each person's age on the plan's effective date, whether they apply individually or as a family. For example, if your 29th birthday is on February 14 and you submit your completed application on January 15, you'll have an effective date of February 1 and the rate for a 28-year-old.

However, if you submit your application on January 16, your effective date will be March 1. Since this is after your birthday, you'll have the rate for a 29-year-old.

Similarly, if you're purchasing coverage for your family, each family member's rate will be based on his or her age on the effective date. (Families are only charged for a maximum of three children under age 21 who are applying for the same plan.)

When figuring out your rate, please keep the following in mind. Although family members can enroll in different plans, there are some advantages to enrolling family members in the same plan:

- In a deductible plan, family members' deductible payments accrue toward the family deductible. In addition, family members' individual out-of-pocket expenses for covered services contribute to the family out-of-pocket maximum in a family plan. Note there are some services that are not subject to the out-of-pocket maximum.
- Children can be covered under your plan until they reach age 26, whether or not they're in school, living at home, or away from the family. But they need to be on the same plan as you.
- Family rates include charges for no more than the three oldest children under age 21. Other children under 21 are covered at no additional cost, as long as they're all covered under the same plan.
- For example, to determine the rate for a family plan, a family of 6 (two adults and 4 children under 21) would calculate their rate by adding the rate for both adults plus the rate for each of the 3 oldest children for a combined family rate. The 4th child (youngest) would be no additional cost.
- You may want to consider different plans with different rates for various family members based on your family's needs. Just keep in mind that you may pay more if you have more than three children under age 21 who are not covered under the same plan.

ZIP codes for Maryland

20588	20768-79	20901-08	21092-94	21273
20601-04	20781-85	20910-16	21102	21275
20607-08	20787-88	20918	21104-06	21278-82
20610	20790-92	20993	21108	21284-90
20612-13	20794	20997	21111	21297-98
20616-17	20797	21001	21113-14	21401-05
20623	20799	21005	21117	21409
20637	20810-18	21009-10	21120	21411-12
20639-40	20824-25	21012-15	21122-23	21701-05
20643	20827	21017-18	21128	21709-10
20646	20830	21020	21130-33	21714
20658	20832-33	21022-23	21136	21716-18
20675	20837-39	21027-32	21139-40	21723
20677-78	20841-42	21034-37	21144	21737-38
20689	20847-55	21040-48	21146	21754-55
20695	20857	21050-54	21150	21757-59
20697	20859-62	21056-57	21152-58	21762
20701	20866	21060-62	21160-63	21765
20703-12	20868	21065	21201-31	21769-71
20714-26	20871-72	21071	21233-37	21774-77
20731-33	20874-80	21074-78	21239-41	21784
20735-38	20882-86	21082	21244	21787
20740-55	20889	21084-85	21250-52	21790-94
20757-59	20891-92	21087-88	21263-64	21797
20762-65	20894-99	21090	21270	

Please verify that your ZIP code is listed above. If it isn't, call us at **1-800-494-5314** for information on other rate areas.

Working out your rate

To calculate the total rate for your health plan for you and your family, just follow these steps:

1. List everyone you want to cover:
   - yourself
   - your spouse/partner
   - all your adult children ages 21 through 25
   - your children under 21
2. Find your preferred plan in the rate chart on the next page.
3. Find the rate for each family member, based on age.
4. For children who are covered under the same plan, include a rate for the three oldest children under 21.
5. Add up the rates.

The worksheet below can help. Go to **buykp.org/apply** or call us or your broker for assistance.

Federal assistance and your rate

If you qualify for financial assistance, these rates do not apply to you. The federal government will pay any financial assistance to Kaiser Permanente on your behalf. To learn more, read the "Do you qualify for financial assistance?" section on page 4.

Your monthly rate worksheet

Plan choice		A	B	C
Family member name	**Family member age**	**Rate for plan A**	**Rate for plan B**	**Rate for plan C**
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
Total premium rate		**$**	**$**	**$**

Preventive care at no extra charge

As you review the rates, keep in mind that many preventive care services are available at no charge before you reach your deductible. That means you get a wide range of services that can help you stay healthy—including general immunizations, diabetes and cancer screenings, counseling for smoking and alcohol abuse, and more. For a complete list of preventive care services, visit **kp.org/prevention**.

Rates

Do you qualify for financial assistance?

If so, you may pay lower rates than those listed in this chart. See page 4 for details.

Monthly rates 2014									
Age on 2014 effective date	KP MD Bronze 5000/30%/HSA Dental/ PedDental	KP MD Bronze 4500/50/HSA Dental/ PedDental	KP MD Bronze 4500/50 Dental/ PedDental	KP MD Silver 1750/25%/HSA Dental/ PedDental	KP MD Silver 2500/30 Dental/ PedDental	KP MD Silver 1500/30 Dental/ PedDental	KP MD Gold 1000/20 Dental/ PedDental	KP MD Gold 0/20 Dental/ PedDental	KP MD Catastrophic 6350/0 Dental/ PedDental[1]
0–20	$112.04	$112.89	$114.75	$134.08	$136.37	$140.88	$155.13	173.62	$107.13
21	176.45	177.78	180.70	211.15	214.75	221.86	244.30	273.41	168.71
22	176.45	177.78	180.70	211.15	214.75	221.86	244.30	273.41	168.71
23	176.45	177.78	180.70	211.15	214.75	221.86	244.30	273.41	168.71
24	176.45	177.78	180.70	211.15	214.75	221.86	244.30	273.41	168.71
25	177.15	178.50	181.42	211.99	215.61	222.75	245.27	274.51	169.38
26	180.68	182.05	185.04	216.21	219.90	227.19	250.16	279.97	172.76
27	184.92	186.32	189.38	221.28	225.06	232.51	256.02	286.54	176.81
28	191.80	193.25	196.42	229.52	233.43	241.16	265.55	297.20	183.39
29	197.45	198.94	202.21	236.27	240.30	248.26	273.37	305.95	188.78
30	200.27	201.79	205.10	239.65	243.74	251.81	277.28	310.32	191.48
31	204.50	206.05	209.43	244.72	248.89	257.14	283.14	316.88	195.53
32	208.74	210.32	213.77	249.79	254.05	262.46	289.00	323.45	199.58
33	211.38	212.99	216.48	252.95	257.27	265.79	292.67	327.55	202.11
34	214.21	215.83	219.37	256.33	260.70	269.34	296.58	331.92	204.81
35	215.62	217.25	220.82	258.02	262.42	271.11	298.53	334.11	206.16
36	217.03	218.67	222.26	259.71	264.14	272.89	300.48	336.30	207.51
37	218.44	220.10	223.71	261.40	265.86	274.66	302.44	338.48	208.86
38	219.85	221.52	225.15	263.09	267.58	276.44	304.39	340.67	210.21
39	222.68	224.36	228.05	266.47	271.01	279.99	308.30	345.05	212.91
40	225.50	227.21	230.94	269.84	274.45	283.54	312.21	349.42	215.61
41	229.74	231.48	235.27	274.91	279.60	288.86	318.07	355.98	219.66
42	233.79	235.56	239.43	279.77	284.54	293.97	323.69	362.27	223.54
43	239.44	241.25	245.21	286.52	291.41	301.06	331.51	371.02	228.94
44	246.50	248.36	252.44	294.97	300.00	309.94	341.28	381.96	235.68
45	254.79	256.72	260.93	304.89	310.10	320.37	352.76	394.81	243.61
46	264.67	266.68	271.05	316.72	322.12	332.79	366.44	410.12	253.06
47	275.79	277.88	282.44	330.02	335.65	346.77	381.83	427.34	263.69
48	288.49	290.68	295.45	345.22	351.11	362.74	399.42	447.03	275.84
49	301.02	303.30	308.28	360.21	366.36	378.49	416.77	466.44	287.82
50	315.14	317.52	322.73	377.11	383.54	396.24	436.31	488.31	301.31
51	329.08	331.57	337.01	393.79	400.51	413.77	455.61	509.91	314.64
52	344.43	347.03	352.73	412.16	419.19	433.07	476.87	533.70	329.32
53	359.95	362.68	368.63	430.74	438.09	452.60	498.36	557.76	344.16
54	376.72	379.57	385.80	450.80	458.49	473.67	521.57	583.73	360.19
55	393.48	396.46	402.97	470.86	478.89	494.75	544.78	609.71	376.22
56	411.65	414.77	421.58	492.60	501.01	517.60	569.94	637.87	393.60
57	430.00	433.26	440.37	514.56	523.34	540.67	595.35	666.31	411.14
58	449.59	452.99	460.43	538.00	547.18	565.30	622.47	696.65	429.87
59	459.29	462.77	470.37	549.61	558.99	577.50	635.90	711.69	439.15
60	478.88	482.51	490.42	573.05	582.83	602.13	663.02	742.04	457.87
61	495.82	499.57	507.77	593.32	603.44	623.43	686.47	768.29	474.07
62	506.94	510.77	519.16	606.62	616.97	637.40	701.86	785.51	484.70
63	520.87	524.82	533.43	623.30	633.94	654.93	721.16	807.11	498.03
64+	529.34	533.34	542.10	633.44	644.25	665.58	732.89	820.23	506.12

Rates are effective January 1, 2014, through December 31, 2014. For tobacco-user rates, call 1-800-494-5314.

[1]Only applicants under age 30, or applicants age 30 and older who provide evidence of eligibility, in the form required by Kaiser Permanente, demonstrating a lack of affordable coverage or financial hardship, may purchase a KP MD Catastrophic 6350/0/Dental/PedDental plan.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply.** • Or contact your agent or broker.

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.

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.

Exclusions:

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under your Agreement. Additional exclusions that apply only to a particular Service are listed in the description of that Service under Section 3 of your Agreement. When a Service is excluded, all Services related to that excluded Service are also excluded, even if they would otherwise be covered under your Agreement.

- Services that are not medically necessary;
- Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
- Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
- 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.
- Services for which a Member is not legally, or as a customary practice, required to pay in the absence of a Health Benefit Plan.
- Except for the pediatric vision benefit provided in Section 3—Benefits of your Agreement, 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.
- Personal Care Services and Domiciliary Care Services.
- Services rendered by a Health Care Practitioner who is a Member's spouse, mother, father, daughter, son, brother or sister.
- Experimental Services. This exclusion does not apply to Services covered under clinical trials in Section 3 of this Agreement.
- 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.
- Services for sterilization or reverse sterilization for a Dependent minor except FDA approved sterilization procedures for women with reproductive capacity.
- Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in Section 3—Benefits of your Agreement.
- Services incurred before the effective date of coverage for a Member.
- Services incurred after a Member's termination of coverage, except as provided in the Extension of Benefits provision in the Termination and Transfer of Membership section of your Agreement.
- Surgery or related 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.
- Services for injuries or diseases related to a Member's job to the extent the Member is required to be covered by a workers' compensation law.
- 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.
- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.
- Inpatient admissions primarily for diagnostic studies, unless authorized by Health Plan.

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- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified under Section 3—Benefits of your Agreement.
- Travel, whether or not recommended by a Health Care Practitioner, except for covered ambulance Services and air travel in connection with a covered transplant.
- Except for Emergency Services, Services received while the Member is outside the United States;
- Immunizations related to foreign travel.
- Unless otherwise specified Section 3—Benefits of your Agreement, in the Adult Dental Plan Appendix, or in the Pediatric Dental Plan Appendix of this Agreement, 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 months of the accident; and
  d. Dental implants.
- Except as covered under the pediatric dental benefit provided in the Pediatric Dental Plan Appendix, accidents occurring while and as a result of chewing.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these Services are determined to be medically necessary.
- 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.
- Inpatient admissions primarily for physical therapy, unless authorized by Health Plan.
- Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery.
- Treatment of sexual dysfunction not related to organic disease.
- Services that duplicate benefits provided under federal, State, or local laws, regulations or programs;
- Non-human organs and their implantation.
- Non-replacement fees for blood and blood products.
- Lifestyle improvements, or physical fitness programs, unless included in Section 3—Benefits of your Agreement.
- Wigs or cranial prosthesis, except for hair prosthesis for a Member whose hair loss was the result of chemotherapy or radiation treatment for cancer.
- Weekend admission charges, except for emergencies and maternity, unless authorized by Health Plan.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- 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 a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
- 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.
- Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
- Services for, or related to, the removal of an organ from a Member for the purposes of transplantation into another person unless the:
  a. Transplant recipient is covered under Health Plan and is undergoing a covered transplant; and,
  b. Services are not payable by another carrier.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Non-medical ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private Hospital room unless authorized by Health Plan.
- Private duty nursing, unless authorized by Health Plan.
- 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.

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Limitations:

We will use our best efforts to provide or arrange for Members' health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under your Agreement, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Office, and complete or partial destruction of facilities. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a Member in procuring the Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician. If you still refuse to accept the recommended Services, Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

Mental Health and Substance Abuse Exclusions:

- Services by pastoral or marital counselors;
- Therapy for sexual problems;
- Treatment for learning disabilities and intellectual disabilities;
- Telephone therapy;
- Travel time to the member's home to conduct therapy;
- Services rendered or billed by schools, or halfway houses or members of their staffs;
- Marriage counseling; and
- Services that are not medically necessary.

Cardiac Rehabilitation Limitations and Exclusions:

- Services must be provided at a facility approved by the Health Plan that is equipped to provide cardiac rehabilitation.
- Maintenance programs are not covered. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

Pulmonary Rehabilitation Limitations and Exclusions:

- Services must be provided at a facility approved by the Health Plan that is equipped to provide pulmonary rehabilitation.
- Maintenance programs are not covered. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

In vitro fertilization Limitation:

- Coverage is limited to three in vitro fertilization attempts per live birth.

Clinical trials Exclusions:

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Prescription drugs

Exclusions:

- Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List.
- 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, except as described in Section 3 – Benefits of your Agreement.

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- Drugs that are not listed in our Preferred Drug List, except as described in this Outpatient Prescription Drug Benefit.
- Drugs that are considered to be experimental or investigational, except as covered in "Clinical Trials" in Section 3—Benefits of your Agreement.
- Except as specifically covered under this Outpatient Prescription Drug Benefit, 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, except as covered in Section 3—Benefits of your Agreement.
- 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, except as covered in Section 3—Benefits of your Agreement.
- 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, except as covered in Section 3—Benefits of your Agreement.
- Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
- 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 (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
- Drugs and devices that are 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. This includes the equipment and supplies associated with the administration of a drug, except as covered in Section 3—Benefits of your Agreement.
- Bandages or dressings, except as covered in Section 3—Benefits of your Agreement.
- Diabetic equipment and supplies, except as covered in Section 3—Benefits of this Agreement.
- 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, except as described in Section 3—Benefits of your Agreement.
- 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.
- Replacement prescriptions necessitated by theft or loss.

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, unless the criteria for coverage of Non-Preferred Brand Drugs has been met. The Non-Preferred Brand Drugs coverage criteria is detailed in the subsection titled, "Preferred Brand vs. Non-Preferred Brand Drugs."
- 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. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in Section 5 of your Agreement.

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Adult dental services

Exclusions:

The following services are not covered under your dental plan Agreement:

- Services which are covered under worker's compensation or employer's liability laws.
- Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the American Dental Association (ADA) guidelines.
- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3 of the Agreement.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
- Dispensing of drugs, except as may be otherwise covered in your medical plan that is described in the Agreement.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as a Covered Dental Service.
- Services provided by a non-Participating Dental Provider or not pre-authorized by Dental Administrator with the exception of out-of-area emergency or urgent care Covered Dental Services and services obtained pursuant to a referral to a non-participating specialist.
- Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a Dental Specialist who will provide Covered Dental Services.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth which, in the opinion of the attending dentist, is not necessary for the patient's dental health.
- The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
- Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
- Services that cannot be performed because of the general health of the patient.
- Implantation and related restorative procedures.
- Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
- Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
- Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in the Agreement.
- Experimental procedures, implantations, or pharmacological regimens which in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Charges for second opinions, unless pre-authorized.
- Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
- Occlusal guards, except for the purpose of controlling habitual grinding.
- Dental services for children under age 19.
- Services related to the treatment of TMD (Temporomandibular disorder).

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- Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a specialist who will provide Covered Dental Services.

Limitations:

Covered dental services are subject to the following limitations:

- Two (2) evaluations are covered per calendar year including a maximum of one (1) comprehensive evaluation.
- One (1) problem focused exam is covered per calendar year.
- Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to two times per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
- One (1) topical fluoride or fluoride varnish is covered per calendar year.
- Two (2) bitewing x-rays are covered per calendar year.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
- Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
- Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
- 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%.
- Relining and rebasing of dentures is limited to once every 24 months.
- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Root planing or scaling is covered once every 24 months per quadrant.
- Full mouth debridement is limited to once per lifetime.
- Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
- Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
- Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.

Pediatric dental services:

Exclusions:

- Services which are covered under worker's compensation or employer's liability laws.
- Services which, in the opinion of the attending dentist, are not necessary for the Member's dental health.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the attending dentist applying American Dental Association (ADA) guidelines.
- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3—Benefits of your Agreement.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations, except as may be otherwise covered in your medical plan as described Section 3—Benefits of your Agreement.
- Dispensing of drugs, except as may be otherwise covered in your medical plan that is described in the Agreement.
- Hospitalization for any dental procedure except as may be otherwise covered in your medical plan which is described in Section 3—Benefits of your Agreement.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as a Covered Dental Service in the Pediatric Dental Plan Schedule of Dental Fees attached to your Agreement.

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- Services provided by a non-Participating Dental Provider or not pre-authorized by Dental Administrator with the exception of out-of-area emergency or urgent care Covered Dental Services and Services obtained pursuant to a referral to a non-participating specialist.
- Services related to the treatment of TMD (Temporomandibular disorder) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires Medically Necessary orthodontia Services.
- Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a specialist who will provide Covered Dental Services.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth which, in the opinion of the attending dentist, is not necessary for the Member's dental health.
- Orthodontic treatment for children who do not have severe dysfunctional handicapping malocclusion. The determination of severe dysfunctional handicapping malocclusion will be made by the treating provider.
- Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
- Services that cannot be performed because of the general health of the Member.
- Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in your Agreement.
- Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in Section 3—Benefits of your Agreement.
- Experimental procedures, implantations, or pharmacological regimens which in the opinion of the attending dentist, are not necessary for the Member's dental health.
- Charges for second opinions, unless pre-authorized.

Limitations:

- Two evaluations (D0120, D0145, D0150, D0160) are covered per calendar year, per Member.
- Two (2) teeth cleanings (D1110 or D1120) per calendar year, per Member.
- Two (2) fluoride applications per calendar year, per Member. Four (4) fluoride varnish treatments are covered per calendar year, per Member for children age three (3) and above; eight (8) topical fluoride varnishes are covered per calendar year, per Member up to age two (2).
- Two (2) bitewing x-rays are covered per calendar year, per Member starting at age two.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
- One (1) sealant per tooth is covered per lifetime, per Member (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
- One (1) space maintainer (D1510, D1520, D1515 or D1525) is covered per 24 months per Member, per arch.
- Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
- Replacement of a crown or denture is covered if it is more than three (3) years from the date of original placement.
- Relining and rebasing of dentures is covered once per 24 months, per Member.
- Root canal treatment is covered once per lifetime per tooth.
- Periodontal scaling and root planing (D4341 or D4342), limited to one (1) per 24 months, per Member, per quadrant.
- Osseous surgery (D4260 or D4261), gingival flap procedure (D4240), and gingivectomy or gingivoplasty (D4210–D4212) are limited to one (1) per 24 months.
- Full mouth debridement is covered once per 24 months, per Member.

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- Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
- Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
- Periodontal maintenance is covered twice per calendar year within 24 months.
- Denture rebase and denture reline is limited to 1 in a 24 month period 6 months after initial placement.
- Anesthesia requires a narrative of medical necessity be maintained in Member records. A maximum of 60 minutes of Services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. General anesthesia is not covered with procedure codes D9230, D9241 or D9242. Intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9220, D9221, D9241 or D9242.
- Occlusal guards are covered by report for Members when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular dysfunction (TMD). Occlusal guards are limited to one per 12 consecutive month period.
- Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary by the attending dentist for documented handicapped or uncontrollable Members or justifiable medical or dental conditions.
- Fixed partial dentures, buildups, and posts and cores for Members under 16 years of age are only covered if deemed necessary by the Participating Dental Provider.
- Onlays, crowns, and posts and cores for members 12 years of age or younger are only covered if deemed necessary by the Participating Dental Provider. Cast posts and cores (D2952) are processed as an alternate benefit of a prefabricated post and core. Posts are eligible only when provided as part of a crown buildup or implant.

To request a full list of exclusions and limitations, please call Member Services at **301-468-6000** or **1-800-777-7902** (TTY **711**), from 7:30 a.m. to 5:30 p.m., Monday through Friday.

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