



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

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2,500 person/ \$5,000 family Does not apply to Preventive Copay. Rx, Adult eyewear, and Adult Dental do not count toward the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. Preferred & Non-preferred brand drugs.: \$ 250 person in network. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	For preferred providers \$6,350 person / \$12,700 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of preferred providers , see www.kp.org or call 1-855-249-5018.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	Yes. You may self refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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

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



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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay	Not Covered	_____none_____
	Specialist visit	\$50 Copay	Not Covered	_____none_____
	Other practitioner office visit	\$50 Copay	Not Covered	Chiro limited to 30 visits per calendar year.
	Preventive care/screening/immunization	\$0 Copay	Not Covered	Cost-sharing will apply if non-preventive services are provided during a scheduled preventive visit.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 Copay	Not Covered	_____none_____
	Imaging (CT/PET scans, MRIs)	\$300 Copay	Not Covered	per test, not per visit
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary .	Generic drugs	Retail:\$15 Copay Mail Order:\$30 Copay	Not Covered	Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge.
	Preferred brand drugs	Retail:\$45 Copay after deductible Mail Order:\$90 Copay after deductible	Not Covered	Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge.
	Non-preferred brand drugs	30% Coinsurance after deductible	Not Covered	Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Specialty drugs	Retail:\$45 Copay after deductible Mail Order:\$90 Copay after deductible	Not Covered	Covers 30 day supply (KP plan pharmacies) & 31-90 day supply of mail order drugs. Women's contraceptives at no charge.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after deductible	Not Covered	_____none_____
	Physician/surgeon fees	30% Coinsurance after deductible	Not Covered	_____none_____
If you need immediate medical attention	Emergency room services	\$400 Copay	\$400 Copay	Copay waived if admitted
	Emergency medical transportation	\$0 Copay	\$0 Copay	Non-licensed ambulance services not covered
	Urgent care	\$50 Copay	Not Covered	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after deductible	Not Covered	_____none_____
	Physician/surgeon fee	30% Coinsurance after deductible	Not Covered	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 Copay	Not Covered	Group Therapy is \$15 copay.
	Mental/Behavioral health inpatient services	30% Coinsurance after deductible	Not Covered	_____none_____
	Substance use disorder outpatient services	\$30 Copay	Not Covered	Group Therapy is \$15 copay.
	Substance use disorder inpatient services	30% Coinsurance after deductible	Not Covered	_____none_____
If you are pregnant	Prenatal and postnatal care	\$0 Copay	Not Covered	Coverage refers to pre and postnatal visits after confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	30% Coinsurance after deductible	Not Covered	_____none_____

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	\$0 Copay	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	Inpatient:30% Coinsurance after deductible Outpatient:\$30 Copay	Not Covered	Inpatient:None Outpatient:PT and OT limited to a combined maximum of 30 visits per calendar year. ST limited to 30 visits per calendar year.
	Habilitation services	\$30 Copay	Not Covered	Outpatient visit limits for PT/OT/ST apply to habilitative and rehabilitative services combined. PT and OT limited to combined maximum of 30 visits per calendar year. ST limit of 30 visits per calendar year.
	Skilled nursing care	30% Coinsurance after deductible	Not Covered	Limited to 100 days per stay.
	Durable medical equipment	30% Coinsurance after deductible	Not Covered	—————none—————
	Hospice service	30% Coinsurance after deductible	Not Covered	—————none—————
If your child needs dental or eye care	Eye exam	\$30 Copay	Not Covered	—————none—————
	Glasses	\$0 Copay	Not Covered	1 Pair per year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic Contacts limited to 3 months supply from selected list
	Dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery 	<ul style="list-style-type: none"> Hearing Aids Long-Term/Custodial Nursing Home Care 	<ul style="list-style-type: none"> Non-Emergency Care when Travelling Outside the U.S. Weight Loss Programs

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

<ul style="list-style-type: none">• Bariatric Surgery• Chiropractic Care with limits• Infertility Treatment with limits	<ul style="list-style-type: none">• Private-Duty Nursing with limits• Routine Dental Services (Adult) with limits• Routine Eye Exam (Adult)	<ul style="list-style-type: none">• Routine Foot Care with limits• Routine Hearing Tests
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Your Rights to Continue Coverage:

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

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

For more information on your rights to continue coverage, contact the insurer at 800-777-7902. You may also contact your state insurance department at 1-866-444-3272.

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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



**This is
not a cost
estimator.**

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,220
- Patient pays \$3,320

Sample care costs:

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

Patient pays:

Deductibles	\$2,500
Co-pays	\$ 20
Co-insurance	\$ 600
Limits or exclusions	\$ 200
Total	\$3,320

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

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

Sample care costs:

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

Patient pays:

Deductibles	\$1,300
Co-pays	\$1,100
Co-insurance	\$ 0
Limits or exclusions	\$ 80
Total	\$2,480

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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