

# Care for all that is you



# Experience health care designed with you in mind

Care for ...

Routine checkups, complex treatments, and late-night questions

Building strength, reducing stress, and raising a family

New goals, old habits, and ongoing mental wellness

No matter what your priority is, ours is providing excellent care – for the you who's feeling great, the you who needs support, and every you in between.



# Go where you feel like your best self

We can help you get to your healthy place – no matter where it is. Care at Kaiser Permanente feels easier and faster, with the help of connected caregivers, more ways to get care, and support for a healthy mind, body, and spirit. Welcome to care for all that is you.

## Important open enrollment dates for 2024

- The open enrollment period for 2024 coverage runs from **November 1, 2023**, through **January 15, 2024**.
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through Maryland Health Connection.
- For coverage that starts on **January 1, 2024**, we must receive your Application for health coverage no later than **December 31, 2023**.

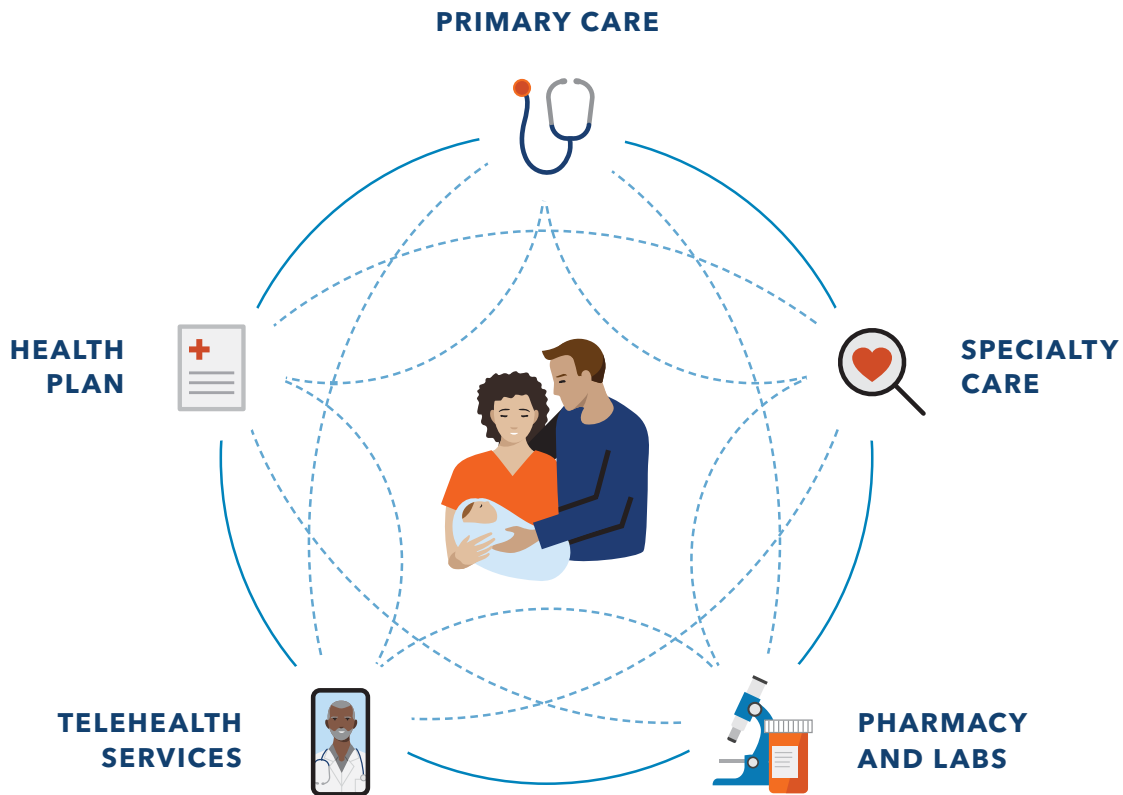
## Enrolling during a special enrollment period

- Are you getting married, moving, or losing your health coverage? You can also enroll or change your coverage at other times throughout the year if you have a qualifying life event.
- Visit [kp.org/specialenrollment](https://kp.org/specialenrollment) for a list of qualifying life events and instructions.

### Want to talk? We're here to help.

A Kaiser Permanente enrollment specialist can answer your questions – like where to get care or what healthy extras are included. Call **1-800-494-5314 (TTY 711)**.





## Built to make your life easier

Combined care and coverage means your Kaiser Permanente doctors, hospitals, and health plan benefits are all connected and committed to providing you with exceptional care tailored to your needs.

It's easier access to specialists and the latest treatments.

It's predictable costs and less paperwork.

It's the care, when you need it.



Find out how we can help you stay healthy and keep doing what you love.

[kp.org/allthatisyouth](https://kp.org/allthatisyouth)

# Care that's **personalized**

For the you who deserves to be understood

Kaiser Permanente doctors have one priority: your health. Your electronic health record connects your care team with your health history, so your doctor can plan the care for your needs. They learn your lifestyle, risks, and goals to understand what matters most to you and be your health advocate.



Explore care that fits your life.

[kp.org/connectedtocare](https://kp.org/connectedtocare)

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We guide you through every step of your care



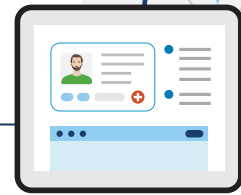
**Your Kaiser Permanente health history lives on your electronic health record.**



**Your doctor guides you through appointments and referrals.**



**Your health record is available to you and your care team 24/7.**



**Your care team lets you know when to schedule checkups and tests.**



# Care that's convenient

## For the you with a busy schedule

Visit [kp.org](https://kp.org) or use our app to make a routine, same-day or next-day appointment in person, or talk to a clinician 24/7 by phone or video.<sup>1</sup> No matter how you connect, you'll talk with a medical professional who can see your health history and pick up where you left off.

### Do more in one visit

Many of our Kaiser Permanente facilities have pharmacies and labs in the same building, so you can see your doctor, get your tests, and pick up your prescriptions all in one stop.

### Your health at your fingertips

- Get 24/7 virtual care
- Email your care team with non-urgent questions
- View most lab results and doctor's notes
- Refill most prescriptions
- Check in for appointments
- Pay bills and view statements



See how the Kaiser Permanente app puts you in control.  
[kp.org/mobile](https://kp.org/mobile)

**FAST COMPANY** | **THE WEBBY AWARDS**

Our mobile app won Fast Company's 2022 Design Company of the Year and the 2022 People's Voice Webby award for Health and Fitness Apps.

### You're covered while traveling



If you're planning to travel, we can help you manage your vaccinations, refill prescriptions, and more. And once you're on the go, you're covered for emergency care anywhere in the world – even at non-Kaiser Permanente facilities.

# Care that's world class

For the you who expects the best

No matter your needs – mental health, maternity, cancer care, heart health, and beyond – you have access to doctors, cutting-edge technology, and evidence-based care.



Learn how our doctors and specialists work for you.

[kp.org/specialtycare](https://kp.org/specialtycare)



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We're a national leader in screening rates and research, and we're among the top-rated health plans in every state we serve.<sup>2,3,4</sup>

Kaiser Permanente members are:



**33%**

**more likely to survive heart disease<sup>5</sup>**

**52%**

**more likely to survive colorectal cancer<sup>6</sup>**

**20%**

**less likely to experience premature death due to cancer<sup>7</sup>**

# Care that's all encompassing

For the you who wants to explore all your health options

Kaiser Permanente members can get help with depression, anxiety, addiction, and mental or emotional health – without a referral. You also have access to self-care apps to help your overall mental wellness.<sup>8,9</sup>



## Calm

The number one app for sleep and meditation<sup>10</sup>



## Ginger

Text one-on-one with an emotional support coach anytime, anywhere<sup>11</sup>



## myStrength

Build a personalized plan to strengthen your emotional health



Find out more about mental health care.

[kp.org/mentalhealth](https://kp.org/mentalhealth)

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## Resources for everyday wellness

Take advantage of classes, services, and programs to help you achieve your health and fitness goals.<sup>12</sup>

- Acupuncture, massage therapy, and chiropractic care
- Reduced rates on gym memberships
- Healthy lifestyle programs
- Wellness coaching
- Online fitness with the ClassPass app

## Explore dental coverage

Kaiser Permanente Smile dental coverage offers enhanced benefits to support improved oral health for whole-body wellness. Starting January 2024, there are new optional dental (adult) and cosmetic orthodontic (adult and child-only) plans available.



Visit [kp.org/dental/mas](https://kp.org/dental/mas) to learn more.



# Care that's **dependable**

**For the you who wants a doctor you trust**

Your health is a lifelong journey, and we want you to have a doctor to go the distance. We hire doctors and staff who often speak more than one language and deliver care that's sensitive to your culture, ethnicity, and lifestyle. And you can choose or change your doctor anytime.



From finding the right doctor to transitioning care, we'll help you with every step.

[kp.org/newmember](https://kp.org/newmember)

“

Dr. Weniger was relatable, kind, and thorough. By the end of my visit, I knew I made the right choice in Kaiser Permanente.

”

– **Aimee**, new member

# Choosing your health plan

We offer a variety of plans to help fit your needs and budget. All of them offer the same quality care, but the way they split the costs is different.

## Virtual plans – silver

With a virtual plan, your monthly premium is lower, and you'll start most care with a virtual visit. Connect to care how you want – choose from 24/7 online chat or advice phone line, e-visit, scheduled video visit, phone appointment, or email for nonurgent issues, all at no additional cost. You'll get the care and prescriptions you need, or help finding in-person care.

## Copay plans – platinum and gold

Copay plans are the simplest. You know in advance how much you'll pay for care like doctor visits and prescriptions. This amount is called your copay. Your monthly premium is higher, but you'll pay much less when you get care.

## KP Plus plans – gold

KP Plus members receive high-quality, comprehensive care from Kaiser Permanente physicians. They can also choose to see any licensed provider outside Kaiser Permanente for certain covered services – with up to 10 out-of-network outpatient medical visits per year, including physician office visits, lab and radiology, as well as up to 5 out-of-network pharmacy refills. Out-of-network payments do not accrue toward in-plan deductibles or out-of-pocket maximum.

Visit [choiceproducts-midatlantic.kaiserpermanente.org/hmo-dhmo-plus/](https://choiceproducts-midatlantic.kaiserpermanente.org/hmo-dhmo-plus/) to learn more.

## Deductible plans – gold, silver, bronze, and catastrophic

With a deductible plan, your monthly premium is lower, but you'll need to pay the full charges for most covered services until you reach a set amount, known as your deductible. Then you'll start paying less – a copay or coinsurance. Depending on your plan, some services, like office visits or prescriptions, may be available at a copay or coinsurance before you reach your deductible.

## HSA-qualified high deductible health plans – bronze

HSA-qualified deductible plans are deductible plans with a special feature. With this plan, you can set up a health savings account (HSA) to pay for health costs like copays, coinsurance, and deductible payments. And you won't pay federal taxes on the money in this account. You can use your HSA anytime to pay for care, including some services that may not be covered by your plan, such as eyeglasses or adult dental.<sup>13</sup> And if you have money left in your HSA at the end of the year, it will roll over for you to use the next year.

# Example of your costs for care

Let's say you hurt your ankle. You visit your personal doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication. Here's an example of what you'd pay out of pocket for these services with each type of health plan.

Plan name	Office visit	X-ray	Most generic drugs (Tier 1)
KP MD Gold 0 Ded/25 RxDed/Vision (no deductible)	\$20	\$65	\$10*
KP MD Silver Virtual Forward 4000/Off (\$4,000 deductible)	Virtual care no charge; First visit in person no charge, and additional visits in person \$55 after deductible**	30% after deductible	\$10*
KP MD Bronze 7200/0%/HSA/Vision (\$7,200 deductible)	No charge after deductible	No charge after deductible	No charge after deductible

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

\*\* Virtual Forward offers virtual care at no charge; includes unlimited access to Chat, email, E-visits, phone and video visits. First in person visit at no charge before you reach your deductible, including primary care visits and outpatient mental health care visits.

The cost estimates above are from [kp.org/treatmentestimates](https://kp.org/treatmentestimates). Visit this site anytime to get an idea of what the charges for common services might be before you reach your deductible.

## Do you qualify for financial help?

You may be eligible for federal or state financial assistance to help you pay for care or coverage. Visit [buykp.org/apply](https://buykp.org/apply) for details.



# Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan's benefits. Review the diagram below to help you understand how to read those charts.

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

Benefit highlights	<span>KP</span> <span>E</span> KP MD Silver 3000 Ded/700 RxDed/Vision
	<span>KP</span> <span>E</span> KP MD Silver 3000 Ded/700 RxDed/Off
Plan type	Deductible
Annual medical deductible (individual/family)	\$3,000/\$6,000
Annual out-of-pocket maximum (individual/family)	\$9,450/\$18,900
<b>Benefits</b>	
<b>Virtual care</b>	
Chat, Email, E-visit, Phone and Video visit	No charge
<b>Preventive care</b>	
Routine physical exam, mammograms, etc.	No charge
<b>Outpatient services (per visit or procedure)</b>	
Primary care office visit	\$35
Specialty care office visit	\$60
Most X-rays	\$85
Most lab tests	\$60
MRI, CT, PET	50% after deductible
Outpatient surgery	40% after deductible
Mental health visit	\$35 (individual therapy)
<b>Inpatient hospital care</b>	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible
<b>Maternity</b>	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	40% after deductible
<b>Emergency and urgent care</b>	
Emergency Department visit	40% after deductible
Urgent care visit	\$60
<b>Prescription drugs (up to a 30-day supply)</b>	
Most generic drugs (Tier 1)	\$20*
Most preferred brand name drugs (Tier 2)	\$80*†
Non-preferred drugs (Tier 3)	40% after \$700 pharmacy deductible per member‡
Specialty drugs (Tier 4)	40% after \$700 pharmacy deductible per member up to \$150 maximum per 30 day prescription
<b>Whole health</b>	
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.

**KP** Offered through Kaiser Permanente  
**E** Offered through the health benefit exchange, Maryland Health Connection

**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 charges for covered services until you reach \$3,000 for yourself or \$6,000 for your family. Then you'd start paying copays or coinsurance.

**Annual out-of-pocket maximum**  
 This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than \$9,450 for yourself and no more than \$18,900 for your family for your copays, coinsurance, and deductible in a calendar year.

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

**Covered before you reach the deductible**  
 With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a \$35 copay even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

**Coinsurance**  
 After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 40% 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 calendar year.

**Copay**  
 This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd start paying a \$60 copay for urgent care visits, whether or not you have met your deductible.

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.  
 † The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

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Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<div style="display: flex; justify-content: space-around;"> <span><b>KP</b></span> <span><b>E</b></span> </div> KP MD Bronze Value 9450/35/Vision		<div style="display: flex; justify-content: space-around;"> <span><b>KP</b></span> <span><b>E</b></span> </div> KP MD Bronze 7200/0%/HSA/Vision		<div style="display: flex; justify-content: space-around;"> <span><b>KP</b></span> <span><b>E</b></span> </div> KP MD Bronze 6700/40/Vision		<div style="display: flex; justify-content: space-around;"> <span><b>KP</b></span> <span><b>E</b></span> </div> KP MD Silver 6000/40/Vision KP MD Silver 6000/40/Vision/Off	
	Plan type	Deductible		HSA-qualified		Deductible		Deductible
Annual medical deductible (individual/family)	\$9,450/\$18,900		\$7,200/\$14,400		\$6,700/\$13,400		\$6,000/\$12,000	
Annual out-of-pocket maximum (individual/family)	\$9,450/\$18,900		\$7,200/\$14,400		\$9,450/\$18,900		\$8,500/\$17,000	
<b>Benefits</b>								
<b>Virtual care</b>								
Chat, Email, E-visit, Phone and Video visit	No charge		Chat, Email, E-visit, Phone and Video visit: No charge after deductible		No charge		No charge	
<b>Preventive care</b>								
Routine physical exam, mammograms, etc.	No charge		No charge		No charge		No charge	
<b>Outpatient services (per visit or procedure)</b>								
Primary care office visit	\$35		No charge after deductible		\$40		\$40	
Specialty care office visit	\$90		No charge after deductible		\$50 after deductible		\$60	
Most X-rays	\$150		No charge after deductible		40% after deductible		\$70	
Most lab tests	\$80		No charge after deductible		40% after deductible		\$50	
MRI, CT, PET	No charge after deductible		No charge after deductible		40% after deductible		35% after deductible	
Outpatient surgery	No charge after deductible		No charge after deductible		40% after deductible		35% after deductible	
Mental health visit	\$35 (individual therapy)		No charge after deductible		\$40 (individual therapy)		\$40 (individual therapy)	
<b>Inpatient hospital care</b>								
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	No charge after deductible		No charge after deductible		40% after deductible		35% after deductible	
<b>Maternity</b>								
Routine prenatal care visit, first postpartum visit	No charge		No charge		No charge		No charge	
Delivery and inpatient well-baby care	No charge after deductible		No charge after deductible		40% after deductible		35% after deductible	
<b>Emergency and urgent care</b>								
Emergency Department visit	No charge after deductible		No charge after deductible		40% after deductible		35% after deductible	
Urgent care visit	\$75		No charge after deductible		\$50 after deductible		\$60	
<b>Prescription drugs (up to a 30-day supply)</b>								
Most generic drugs (Tier 1)	\$25*		No charge after deductible		\$20*		\$30*	
Most preferred brand name drugs (Tier 2)	No charge after deductible		No charge after deductible		40% after deductible†		\$60*†	
Non-preferred drugs (Tier 3)	No charge after deductible		No charge after deductible		50% after deductible†		50% after deductible†	
Specialty drugs (Tier 4)	No charge after deductible		No charge after deductible		50% after deductible up to \$150 maximum per 30 day prescription		50% after deductible up to \$150 maximum per 30 day prescription	
<b>Whole health</b>								
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.							

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

† The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit [kp.org/plandocuments](http://kp.org/plandocuments), call us at 1-800-777-7902 (TTY 711), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

**KP** Offered through Kaiser Permanente

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Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<b>KP</b> <b>E</b>	<b>KP</b> <b>E</b>	<b>KP</b> <b>E</b>	<b>KP</b> <b>E</b>
	KP MD Silver Virtual Forward 5000	KP MD Silver Value 4500 Ded/750 RxDed/Vision KP MD Silver Value 4500 Ded/750 RxDed/Vision/ Off	KP MD Silver Virtual Forward 4000 KP MD Silver Virtual Forward 4000/Off	KP MD Silver 3000 Ded/700 RxDed/Vision KP MD Silver 3000 Ded/700 RxDed/Off
Plan type	Deductible	Deductible	Deductible	Deductible
Annual medical deductible (individual/family)	\$5,000/\$10,000	\$4,500/\$9,000	\$4,000/\$8,000	\$3,000/\$6,000
Annual out-of-pocket maximum (individual/family)	\$7,800/\$15,600	\$7,600/\$15,200	\$8,000/\$16,000	\$9,450/\$18,900
<b>Benefits</b>				
<b>Virtual care</b>				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge
<b>Preventive care</b>				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>				
Primary care office visit	Virtual care no charge; First visit in person no charge, and additional visits in person \$55 after deductible <sup>††</sup>	\$35	Virtual care no charge; First visit in person no charge, and additional visits in person \$55 after deductible <sup>††</sup>	\$35
Specialty care office visit	\$75 after deductible	\$90	\$75 after deductible	\$60
Most X-rays	30% after deductible	\$150	30% after deductible	\$85
Most lab tests	\$75 after deductible	\$80	\$75 after deductible	\$60
MRI, CT, PET	30% after deductible	\$600 after deductible	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	\$300 after deductible	30% after deductible	40% after deductible
Mental health visit	Virtual care no charge; First visit in person no charge, and additional visits in person \$55 after deductible <sup>††</sup>	\$35 (individual therapy)	Virtual care no charge; First visit in person no charge, and additional visits in person \$55 after deductible <sup>††</sup>	\$35 (individual therapy)
<b>Inpatient hospital care</b>				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	\$550 per admission after deductible	30% after deductible	40% after deductible
<b>Maternity</b>				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	\$550 per admission after deductible	30% after deductible	40% after deductible
<b>Emergency and urgent care</b>				
Emergency Department visit	30% after deductible	\$500 after deductible (waived if admitted)	30% after deductible	40% after deductible
Urgent care visit	\$75 after deductible	\$75	\$75 after deductible	\$60
<b>Prescription drugs (up to a 30-day supply)</b>				
Most generic drugs (Tier 1)	\$20*	\$25, pharmacy out-of-pocket maximum applies*	\$10*	\$20*
Most preferred brand name drugs (Tier 2)	\$50 after deductible <sup>†,‡</sup>	\$75 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies <sup>‡</sup>	\$50 after deductible <sup>†,‡</sup>	\$80 <sup>†,‡</sup>
Non-preferred drugs (Tier 3)	50% after deductible <sup>†</sup>	\$80 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies <sup>‡</sup>	50% after deductible <sup>†</sup>	40% after \$700 pharmacy deductible per member <sup>‡</sup>
Specialty drugs (Tier 4)	50% after deductible up to \$150 maximum per 30 day prescription	\$100 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies	50% after deductible up to \$150 maximum per 30 day prescription	40% after \$700 pharmacy deductible per member up to \$150 maximum per 30 day prescription
<b>Whole health</b>				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.			

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Benefit highlights	<b>KP</b> <b>E</b> KP MD Gold 1750 Ded/250 RxDed/Vision	<b>KP</b> <b>E</b> KP MD Gold Plus 1700/20/Vision	<b>KP</b> <b>E</b> KP MD Gold 1100 Ded/200 RxDed/Vision	<b>KP</b> <b>E</b> KP MD Gold Value 1000 Ded/150 RxDed/Vision
	Deductible	Deductible	Deductible	Deductible
<b>Plan type</b>	<b>Deductible</b>	<b>Deductible</b>	<b>Deductible</b>	<b>Deductible</b>
Annual medical deductible (individual/family)	\$1,750/\$3,500	\$1,700/\$3,400	\$1,100/\$2,200	\$1,000/\$2,000
Annual out-of-pocket maximum (individual/family)	\$6,450/\$12,900	\$8,300/\$16,600	\$6,950/\$13,900	\$6,750/\$13,500
<b>Benefits</b>				
<b>Virtual care</b>				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge <sup>†††</sup>	No charge	No charge
<b>Preventive care</b>				
Routine physical exam, mammograms, etc.	No charge	No charge <sup>†††</sup>	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>				
Primary care office visit	\$20	20 <sup>†††</sup>	\$15	\$10
Specialty care office visit	\$40	50 <sup>†††</sup>	\$35	\$30
Most X-rays	\$70	65 <sup>†††</sup>	\$65	\$50
Most lab tests	\$50	15 <sup>†††</sup>	\$40	\$25
MRI, CT, PET	35% after deductible	\$250	\$500	\$400 after deductible
Outpatient surgery	35% after deductible	35% after deductible	25% after deductible	\$375
Mental health visit	\$20 (individual therapy)	\$20 (individual therapy) <sup>†††</sup>	\$15 (individual therapy)	\$10 (individual therapy)
<b>Inpatient hospital care</b>				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	35% after deductible	25% after deductible	\$450 per admission after deductible
<b>Maternity</b>				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	35% after deductible	25% after deductible	\$450 per admission after deductible
<b>Emergency and urgent care</b>				
Emergency Department visit	35% after deductible	\$300 after deductible (waived if admitted)	\$500 (waived if admitted)	\$350 after deductible (waived if admitted)
Urgent care visit	\$40	\$50	\$35	\$40
<b>Prescription drugs (up to a 30-day supply)</b>				
Most generic drugs (Tier 1)	\$15 <sup>*</sup>	\$10 <sup>*†††</sup>	\$10 <sup>*</sup>	\$10, pharmacy out-of-pocket maximum applies <sup>*</sup>
Most preferred brand name drugs (Tier 2)	\$55 after \$250 pharmacy deductible per member <sup>*‡</sup>	\$50 after deductible <sup>*‡†††</sup>	\$55 <sup>*‡</sup>	\$30, pharmacy out-of-pocket maximum applies <sup>*‡</sup>
Non-preferred drugs (Tier 3)	50% after \$250 pharmacy deductible per member <sup>*‡</sup>	\$100 after deductible <sup>*‡†††</sup>	25% after \$200 pharmacy deductible per member <sup>*‡</sup>	\$60 after \$150 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies <sup>*‡</sup>
Specialty drugs (Tier 4)	50% after \$250 pharmacy deductible per member up to \$150 maximum per 30 day prescription	\$150 after deductible <sup>*‡†††</sup>	25% after \$200 pharmacy deductible per member up to \$150 maximum per 30 day prescription	\$75 after \$150 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies
<b>Whole health</b>				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.			

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

‡ The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

††† With KP Plus, you're covered for up to 10 out-of-network outpatient medical visits per year, including physician office visits, lab and radiology, as well as up to 5 out-of-network pharmacy refills. Out-of-network payments do not accrue toward in-plan deductibles or out-of-pocket maximum.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit [kp.org/plandocuments](http://kp.org/plandocuments), call us at 1-800-777-7902 (TTY 711), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

**KP** Offered through Kaiser Permanente

**E** Offered through the health benefit exchange, Maryland Health Connection

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<b>KP</b> <b>E</b>	<b>KP</b> <b>E</b>	<b>KP</b> <b>E</b>
	KP MD Gold 0 Ded/25 RxDed/Vision	KP MD Platinum 0/15/Vision	KP MD Catastrophic <sup>††</sup> 9450 Ded/Vision
Plan type	<b>Copayment</b>		<b>Deductible</b>
Annual medical deductible (individual/family)	None/None	None/None	\$9,450/\$18,900
Annual out-of-pocket maximum (individual/family)	\$8,000/\$16,000	\$3,900/\$7,800	\$9,450/\$18,900
<b>Benefits</b>			
<b>Virtual care</b>			
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	Chat, Email, E-visit, Phone and Video visit: No charge after deductible
<b>Preventive care</b>			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>			
Primary care office visit	\$20	\$15	First 3 office visits no charge. <sup>***</sup> Additional visits no charge after deductible.
Specialty care office visit	\$40	\$20	No charge after deductible
Most X-rays	\$65	\$20	No charge after deductible
Most lab tests	\$30	\$20	No charge after deductible
MRI, CT, PET	\$500	\$250	No charge after deductible
Outpatient surgery	35%	\$350	No charge after deductible
Mental health visit	\$20 (individual therapy)	\$15 (individual therapy)	First 3 office visits no charge. <sup>***</sup> Additional visits no charge after deductible.
<b>Inpatient hospital care</b>			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35%	\$350 per day up to 4 days <sup>**</sup>	No charge after deductible
<b>Maternity</b>			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35%	\$350 per day up to 4 days <sup>**</sup>	No charge after deductible
<b>Emergency and urgent care</b>			
Emergency Department visit	\$500 (waived if admitted)	\$300 (waived if admitted)	No charge after deductible
Urgent care visit	\$40	\$20	No charge after deductible
<b>Prescription drugs (up to a 30-day supply)</b>			
Most generic drugs (Tier 1)	\$10 <sup>*</sup>	\$5 <sup>*</sup>	No charge after deductible
Most preferred brand name drugs (Tier 2)	\$55 <sup>*†</sup>	\$35 <sup>*†</sup>	No charge after deductible
Non-preferred drugs (Tier 3)	35% after \$25 pharmacy deductible per member <sup>†</sup>	\$55 <sup>*†</sup>	No charge after deductible
Specialty drugs (Tier 4)	35% after \$25 pharmacy deductible per member up to \$150 maximum per 30 day prescription	\$150 <sup>*</sup>	No charge after deductible
<b>Whole health</b>			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.		

<sup>\*\*</sup> After day maximum is met, there is no charge for covered services related to this admission.

<sup>\*</sup> Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

<sup>††</sup> Only applicants younger than age 30 or applicants age 30 and older who receive an exemption due to lack of affordable coverage or hardship may enroll in this plan. To apply for an exemption, please go to [marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf](http://marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf) and follow the instructions.

<sup>†</sup> The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit [kp.org/plandocuments](http://kp.org/plandocuments), call us at **1-800-777-7902 (TTY 711)**, 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.



**E** Offered through the health benefit exchange, Maryland Health Connection

## Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<b>E</b>	<b>E</b>	<b>E</b>	<b>E</b>
	KP MD Silver Value 4500 Ded/750 RxDed/CSR/Vision	KP MD Silver Value 1000 Ded/150 RxDed/CSR/Vision	KP MD Silver Value 0 Ded/CSR/Vision	KP MD Silver 3800/35/CSR/Vision
Plan type	<b>Deductible</b>	<b>Deductible</b>	<b>Copayment</b>	<b>Deductible</b>
Annual medical deductible (individual/family)	\$4,500/\$9,000	\$1,000/\$2,000	None/None	\$3,800/\$7,600
Annual out-of-pocket maximum (individual/family)	\$6,050/\$12,100	\$2,500/\$5,000	\$1,750/\$3,500	\$7,250/\$14,500
<b>Benefits</b>				
<b>Virtual care</b>				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge
<b>Preventive care</b>				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>				
Primary care office visit	\$35	\$10	\$2	\$35
Specialty care office visit	\$90	\$30	\$15	\$55
Most X-rays	\$150	\$50	\$20	\$55
Most lab tests	\$80	\$25	\$5	\$40
MRI, CT, PET	\$600 after deductible	\$350 after deductible	\$125	35% after deductible
Outpatient surgery	\$300 after deductible	\$200	\$110	35% after deductible
Mental health visit	\$35 (individual therapy)	\$10 (individual therapy)	\$2	\$35 (individual therapy)
<b>Inpatient hospital care</b>				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	\$550 per admission after deductible	\$350 per admission after deductible	\$150 per admission	35% after deductible
<b>Maternity</b>				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	\$550 per admission after deductible	\$350 per admission after deductible	\$150 per admission	35% after deductible
<b>Emergency and urgent care</b>				
Emergency Department visit	\$500 after deductible (waived if admitted)	\$150 after deductible (waived if admitted)	\$75 (waived if admitted)	35% after deductible
Urgent care visit	\$75	\$30	\$15	\$55
<b>Prescription drugs (up to a 30-day supply)</b>				
Most generic drugs (Tier 1)	\$25, pharmacy out-of-pocket maximum applies*	\$5, pharmacy out-of-pocket maximum applies*	No charge, pharmacy out-of-pocket maximum applies*	\$25*
Most preferred brand name drugs (Tier 2)	\$75 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies†	\$25 after \$150 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies†	\$5, pharmacy out-of-pocket maximum applies*†	\$60*†
Non-preferred drugs (Tier 3)	\$80 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies†	\$50 after \$150 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies†	\$15, pharmacy out-of-pocket maximum applies†	35% after deductible†
Specialty drugs (Tier 4)	\$100 after \$750 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies	\$60 after \$150 pharmacy deductible, per member; pharmacy out-of-pocket maximum applies	\$25, pharmacy out-of-pocket maximum applies†	35% after deductible up to \$150 maximum per 30 day prescription
<b>Whole health</b>				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.			

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

† The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit [kp.org/plandocuments](http://kp.org/plandocuments), call us at 1-800-777-7902 (TTY 711), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

**E** Offered through the health benefit exchange, Maryland Health Connection

## Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<b>E</b>	<b>E</b>	<b>E</b>	<b>E</b>
	KP MD Silver 0/15/CSR/Vision	KP MD Silver 0/3/CSR/Vision	KP MD Silver 3000 Ded/700 RxDed/CSR/Vision	KP MD Silver 0 Ded/50 RxDed/CSR/Vision
Plan type	<b>Copayment</b>	<b>Copayment</b>	<b>Deductible</b>	<b>Copayment</b>
Annual medical deductible (individual/family)	None/None	None/None	\$3,000/\$6,000	None/None
Annual out-of-pocket maximum (individual/family)	\$3,150/\$6,300	\$2,000/\$4,000	\$7,550/\$15,100	\$3,150/\$6,300
<b>Benefits</b>				
<b>Virtual care</b>				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge
<b>Preventive care</b>				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>				
Primary care office visit	\$15	\$3	\$35	\$10
Specialty care office visit	\$40	\$15	\$60	\$40
Most X-rays	\$40	\$15	\$85	\$40
Most lab tests	\$40	\$10	\$60	\$40
MRI, CT, PET	30%	10%	50% after deductible	30%
Outpatient surgery	30%	10%	40% after deductible	30%
Mental health visit	\$15 (individual therapy)	\$3	\$35 (individual therapy)	\$10 (individual therapy)
<b>Inpatient hospital care</b>				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30%	10%	40% after deductible	30%
<b>Maternity</b>				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30%	10%	40% after deductible	30%
<b>Emergency and urgent care</b>				
Emergency Department visit	30%	10%	40% after deductible	30%
Urgent care visit	\$40	\$15	\$60	\$40
<b>Prescription drugs (up to a 30-day supply)</b>				
Most generic drugs (Tier 1)	\$15*	\$3*	\$20*	\$10*
Most preferred brand name drugs (Tier 2)	\$60*†	\$15*	\$80*†	\$60*†
Non-preferred drugs (Tier 3)	30%†	10%†	40% after \$700 pharmacy deductible per member†	30% after \$50 pharmacy deductible per member†
Specialty drugs (Tier 4)	30% up to \$150 maximum per 30 day prescription	10% up to \$150 maximum per 30 day prescription	40% after \$700 pharmacy deductible per member up to \$150 maximum per 30 day prescription	30% after \$50 pharmacy deductible per member up to \$150 maximum per 30 day prescription
<b>Whole health</b>				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.			

\* Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

† The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

This plan summary highlights the benefits, copays, coinsurance, and deductibles that are most frequently asked about. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit [kp.org/plandocuments](http://kp.org/plandocuments), call us at 1-800-777-7902 (TTY 711), 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. The out-of-pocket maximum includes the annual deductible. Most copays and coinsurance contribute to the out-of-pocket maximum.

**E** Offered through the health benefit exchange, Maryland Health Connection

## Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through [marylandhealthconnection.gov](http://marylandhealthconnection.gov).

Benefit highlights	<b>E</b>	<b>E</b>	<b>E</b>	<b>E</b>
	KP MD Silver 0 Ded/CSR/Vision	KP MD Silver Virtual Forward 2500/CSR	KP MD Silver Virtual Forward 750/CSR	KP MD Silver Virtual Forward 100/CSR
Plan type	<b>Copayment</b>	<b>Deductible</b>	<b>Deductible</b>	<b>Deductible</b>
Annual medical deductible (individual/family)	None/None	\$2,500/\$5,000	\$750/\$1,500	\$100/\$200
Annual out-of-pocket maximum (individual/family)	\$2,100/\$4,200	\$7,550/\$15,100	\$2,100/\$4,200	\$850/\$1,700
<b>Benefits</b>				
<b>Virtual care</b>				
Chat, Email, E-visit, Phone and Video visit	No charge	No charge	No charge	No charge
<b>Preventive care</b>				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
<b>Outpatient services (per visit or procedure)</b>				
Primary care office visit	\$5	Virtual care no charge; First visit in person no charge, and additional visits in person \$45 after deductible <sup>††</sup>	Virtual care no charge; First visit in person no charge, and additional visits in person \$35 after deductible <sup>††</sup>	Virtual care no charge; First visit in person no charge, and additional visits in person \$25 after deductible <sup>††</sup>
Specialty care office visit	\$15	\$65 after deductible	\$55 after deductible	\$45 after deductible
Most X-rays	\$20	20% after deductible	10% after deductible	5% after deductible
Most lab tests	\$5	\$65 after deductible	\$55 after deductible	\$45 after deductible
MRI, CT, PET	10%	20% after deductible	10% after deductible	5% after deductible
Outpatient surgery	10%	20% after deductible	10% after deductible	5% after deductible
Mental health visit	\$5	Virtual care no charge; First visit in person no charge, and additional visits in person \$45 after deductible <sup>††</sup>	Virtual care no charge; First visit in person no charge, and additional visits in person \$35 after deductible <sup>††</sup>	Virtual care no charge; First visit in person no charge, and additional visits in person \$25 after deductible <sup>††</sup>
<b>Inpatient hospital care</b>				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	10%	20% after deductible	10% after deductible	5% after deductible
<b>Maternity</b>				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	10%	20% after deductible	10% after deductible	5% after deductible
<b>Emergency and urgent care</b>				
Emergency Department visit	10%	20% after deductible	10% after deductible	5% after deductible
Urgent care visit	\$15	\$65 after deductible	\$55 after deductible	\$45 after deductible
<b>Prescription drugs (up to a 30-day supply)</b>				
Most generic drugs (Tier 1)	\$5 <sup>*</sup>	\$10 <sup>*</sup>	\$10 <sup>*</sup>	\$3 <sup>*</sup>
Most preferred brand name drugs (Tier 2)	\$10 <sup>*</sup>	\$50 after deductible <sup>*†</sup>	\$30 after deductible <sup>*</sup>	\$20 after deductible <sup>*</sup>
Non-preferred drugs (Tier 3)	10% <sup>†</sup>	50% after deductible <sup>†</sup>	20% after deductible <sup>†</sup>	5% after deductible <sup>*†</sup>
Specialty drugs (Tier 4)	20% up to \$150 maximum per 30 day prescription	50% after deductible up to \$150 maximum per 30 day prescription	20% after deductible up to \$150 maximum per 30 day prescription	5% after deductible up to \$150 maximum per 30 day prescription
<b>Whole health</b>				
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit <a href="http://kp2020.org">kp2020.org</a> for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit <a href="http://kp.org/selfcare">kp.org/selfcare</a> for more details.			

<sup>\*</sup> Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

<sup>†</sup> The cost of medications to treat conditions such as diabetes, HIV, or AIDS medications may be less than those shown.

<sup>††</sup> Virtual Forward offers virtual care at no charge; includes unlimited access to Chat, email, E-visits, phone and video visits. First in person visit at no charge before you reach your deductible, including primary care visits and outpatient mental health care visits.

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# Find your rate



Apply on [buykp.org/apply](https://buykp.org/apply) to have your rate calculated automatically.

## How is your rate determined?

### Your rate is based on:

- The plan you choose
- Where you live, based on your county and ZIP code
- Your age on your plan start date (effective date)
- If you qualify for federal financial assistance. Visit [buykp.org/apply](https://buykp.org/apply) or call us at **1-800-494-5314** to see if you may qualify.
- If you add an optional dental rider for family members 19 and older

## Interested in a family plan?

Find the rate for each family member, based on his or her age on the start date.

Family members include:

- You
- Your spouse/domestic partner
- All adult children 21 through 25
- Your 3 oldest children under 21

If you have more than 3 children under 21, you only need to pay for the 3 oldest. The other children under 21 will be covered at no charge.

## Additional financial assistance for some young adults

If you are between 18 and 37, you may qualify for even more financial assistance due to new legislation in Maryland. To find out more, visit [marylandhealthconnection.gov](https://marylandhealthconnection.gov) or call us at **1-800-255-5169**.

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

### ZIP codes for Maryland

20588	20781-85	20918	21108	21284-87
20601-04	20787-88	20993	21111	21289-90
20607-08	20790-92	20997	21113-14	21297-98
20610	20794	21001	21117	21401-05
20612-13	20797	21005	21120	21409
20616-17	20799	21009-10	21122-23	21411-12
20623	20810-18	21012-15	21128	21701-05
20637	20824-25	21017-18	21130-33	21709-10
20639-40	20827	21020	21136	21714
20643	20830	21022-23	21139-40	21716-18
20645-46	20832-33	21027-32	21144	21723
20658	20837-39	21034-37	21146	21737-38
20675	20841-42	21040-48	21150	21754-55
20677-78	20847-55	21050-54	21152-58	21757-59†
20689	20857	21056-57	21160-63	21762
20695	20859-62	21060-62	21201-31	21765
20697	20866	21065	21233-37	21769-71†
20701	20868	21071	21239-41	21774-77
20703-12	20871-72	21074-78	21244	21784
20714-26	20874-80	21082	21250-52	21787†
20731-33	20882-86	21084-85	21263-64	21790-94
20735-38	20889	21087-88	21270	21797
20740-55	20891-92	21090	21273	
20757-59	20894-99	21092-94	21275	
20762-65	20901-08	21102	21278-79	
20768-79	20910-16	21104-06	21281-82	

† Portions of ZIP code not in service area: 21758, 21769, and 21787.

# Kaiser Permanente medical facilities



Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or visit [kp.org/facilities](https://kp.org/facilities) to find the one nearest you.

## Maryland

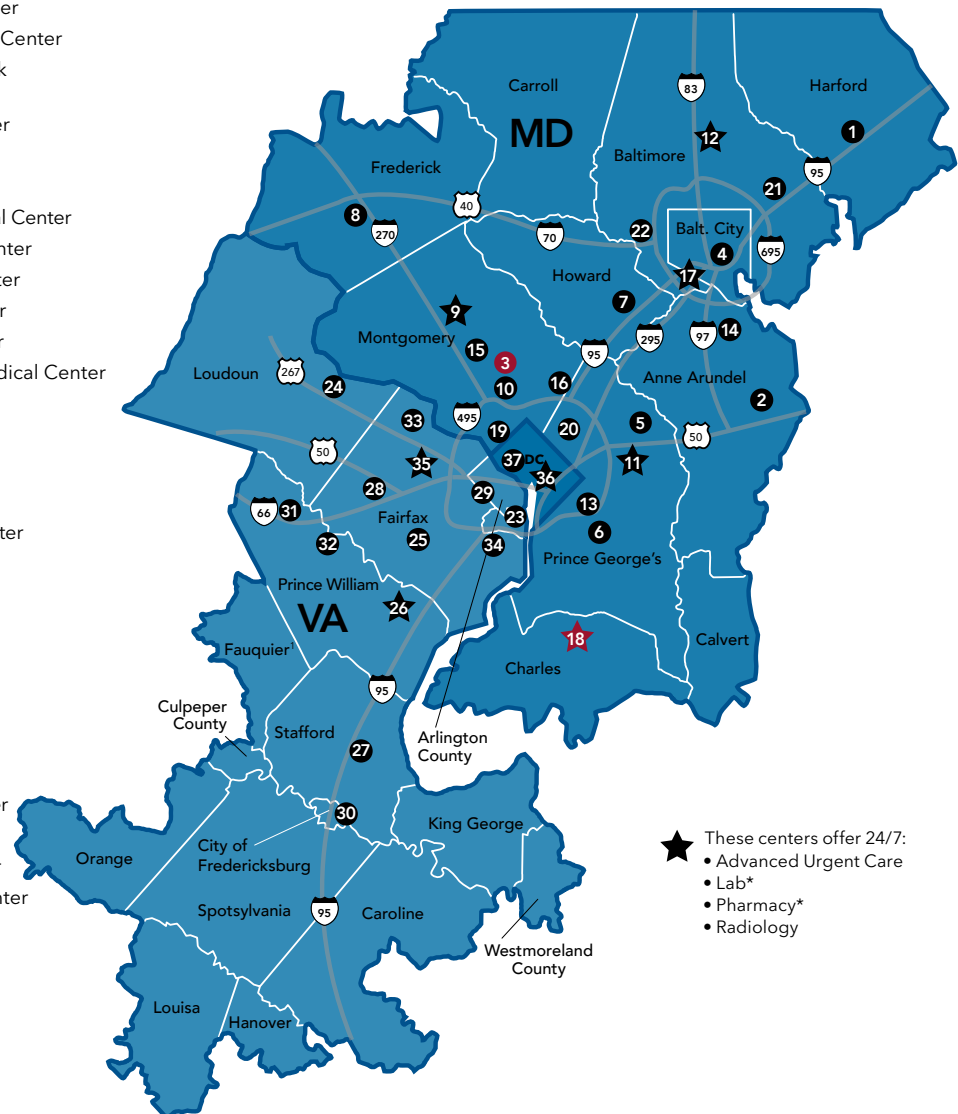
- 1 Abingdon Medical Center
- 2 Annapolis Medical Center
- 3 **FUTURE LOCATION**  
Medical Center in Aspen Hill
- 4 Kaiser Permanente Baltimore Harbor Medical Center
- 5 Bowie Fairwood Medical Center
- 6 Camp Springs Medical Center
- 7 Columbia Gateway Medical Center
- 8 Kaiser Permanente Frederick Medical Center
- 9 Gaithersburg Medical Center
- 10 Kensington Medical Center
- 11 Largo Medical Center
- 12 Lutherville-Timonium Medical Center
- 13 Marlow Heights Medical Center
- 14 North Arundel Medical Center
- 15 Shady Grove Medical Center
- 16 Silver Spring Medical Center
- 17 South Baltimore County Medical Center
- 18 **FUTURE LOCATION**  
Medical Center in Waldorf
- 19 *well* Friendship Heights  
by KAISSER PERMANENTE
- 20 West Hyattsville Medical Center
- 21 White Marsh Medical Center
- 22 Woodlawn Medical Center

## Virginia

- 23 Alexandria Medical Center
- 24 Ashburn Medical Center
- 25 Burke Medical Center
- 26 Caton Hill Medical Center
- 27 Colonial Forge Medical Center
- 28 Fair Oaks Medical Center
- 29 Falls Church Medical Center
- 30 Fredericksburg Medical Center
- 31 Haymarket Crossroads Medical Center
- 32 Manassas Medical Center

## Washington, DC

- 33 Reston Medical Center
- 34 Springfield Medical Center
- 35 Tysons Corner Medical Center
- 36 Kaiser Permanente Capitol Hill Medical Center
- 37 Northwest DC Medical Office Building



- ★ These centers offer 24/7:
  - Advanced Urgent Care
  - Lab\*
  - Pharmacy\*
  - Radiology

\*Extended pharmacy hours at Gaithersburg and Lutherville-Timonium and extended lab hours at Tysons Corner.

For our most up-to-date listing of facilities and services available, please check [kp.org/facilities](https://kp.org/facilities).

Kaiser Permanente's service area in Fauquier County includes the following ZIP codes: 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20188, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728, and 22739.

# Benefits, Exclusions, and Limitations

## Medical Exclusions

This provision provides information on what services we will not pay for regardless of whether or not the service is medically necessary.

When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service.

For example, if you have a non-covered cosmetic surgery, we will not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication, such as a serious infection, this exclusion will not apply and we would cover any services that we would otherwise cover to treat that complication.

The following services are excluded from coverage:

1. Services that are not medically necessary;
2. Services performed or prescribed under the direction of a person who is not a health care practitioner;
3. Services that are beyond the scope of practice of the health care practitioner performing the service;
4. Other 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;
5. Services for which a member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan;
6. Except for pediatric vision benefits, 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;
7. Personal care services and domiciliary care services;
8. Services rendered by a health care practitioner who is a member's spouse, mother, father, daughter, son, brother or sister;
9. Experimental services, except when part of a clinical trial;
10. 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;
11. Medical or surgical treatment for reducing or controlling weight;
12. Services incurred before the effective date of coverage for a member;
13. Services incurred after a member's termination of coverage;
14. Cosmetic Services, including surgery or related services and other 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.
15. 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;
  16. 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;
  17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment;
  18. Except for a covered telehealth consultation, charges for telephone consultations, failure to keep a scheduled visit or completion of any form.
  19. Inpatient admissions primarily for diagnostic studies, unless authorized by us;
  20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers;
  21. Travel, whether or not it is recommended by a health care practitioner, except for:
    - a. Covered ambulance services; and
    - b. Travel in connection with a covered transplant.
  22. Except for emergency services and urgent care services, services received while the member is outside of the United States;
  23. Immunizations related to foreign travel.
  24. Dental work or treatment that 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 (6) months of the accident; and
    - d. Dental implants.
  25. Accidents occurring while and as a result of chewing;
  26. 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;
  27. Inpatient admissions primarily for physical therapy, unless authorized by us;
  28. Treatment of sexual dysfunction not related to organic disease;
  29. Services that duplicate benefits provided under federal, state or local laws, regulations or programs;
  30. Non-human organs and their implantation;
  31. Non-replacement fees for blood and blood products;
  32. Lifestyle improvements or physical fitness programs;
  33. Wigs or cranial prosthesis, except for one (1) medically necessary hair prosthesis;
  34. Weekend admission charges, except for emergencies and maternity, unless authorized by us;

35. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements;
36. 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;
37. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution;
38. 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 one of our plan's and is undergoing a covered transplant; and
  - b. Services are not payable by another carrier.
39. Physical examinations required for obtaining or continuing employment, insurance or government licensing;
40. Non-medical ancillary services such as vocational rehabilitation, employment counseling or educational therapy;
41. A private hospital room unless medically necessary and authorized by us;
42. Private duty nursing, unless authorized by us;
43. 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.

## Medical Limitations

We will make our best efforts to provide or arrange for your health care services in the event of unusual circumstances, for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a plan hospital or plan medical center; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide services, we, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente's Medical Group Plan 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 Commissioner of Insurance.

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, we and plan providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

## Pharmacy Exclusions

Except as specifically covered, the Health Plan does not cover:

1. Weight management drugs;
2. Sexual dysfunction drugs;
3. A drug that can be obtained without a



prescription, except for over-the-counter contraceptive drugs; or

4. A drug for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits.

## Pharmacy Limitations

Except for maintenance medications and contraceptive drugs, members may obtain up to a thirty (30)-day supply and will be charged the applicable cost share based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one cost share at the initial dispensing for each thirty (30)-day supply.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

1. The prescriber determines dispensing a partial supply of a prescription drug to be in the best interest of the member;
2. The prescription drug is anticipated to be required for more than three (3) months;
3. The member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the

member's prescription drugs;

4. The prescription drug is not a Schedule II controlled dangerous substance; and
5. The supply and dispensing of the prescription drug meet all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

Except for maintenance medications and contraceptive drugs as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

For maintenance medications, members may obtain up to a ninety (90)-day supply of in a single prescription, when authorized by the prescribing plan provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

1. The prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

Except for prescription drugs to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), if a drug meets the criteria for a Specialty Drug, then the Member's cost for the drug will not exceed \$150 for a thirty (30)-day supply, in accordance with §15-847 of the Insurance Article. For all insulin, the Member's cost will not exceed \$30 for a 30-day supply, regardless of the amount or type of insulin, in accordance with §15-822.1 of the Insurance Article.

For prescribed contraceptives, members may obtain up to a twelve (12)-month supply for a single dispense at a plan pharmacy or through our mail service delivery program.

## Dental Exclusions

The following exclusions apply to covered dental services for children under age nineteen (19) years:

1. Any procedures not listed on this plan
2. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
3. Dental procedures or services performed solely for cosmetic purposes or that is not dentally necessary and/or medically necessary; unless the member has purchased the additional cosmetic Ortho Plus Plan and services are within the benefit guidelines listed in the cosmetic Ortho Plus Plan.
4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving you or your dependent's dental health, as determined by the plan based on generally accepted dental standards of care.
5. For elective procedures, including prophylactic extraction of third molars.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged.
7. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
8. Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as covered service.
9. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
10. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
11. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits.
12. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.
13. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.
14. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded from Orthodontic benefits.
15. Broken appointments unless specifically covered.

# Complete care to help you live a fuller, healthier life

With Kaiser Permanente, you have a trusted partner who considers your health a priority and makes it easier to get the care you need. That's why members stay with Kaiser Permanente nearly 3 times as long as other health plans.<sup>14</sup>

## Want to learn more?



Visit [kp.org/allthatisyou](https://kp.org/allthatisyou) to shop plans and get help with your health care questions.

Call **1-800-494-5314** (TTY **711**) to talk to an enrollment specialist.

Current members with questions can call Member Services at **1-800-777-7902** (TTY **711**), Monday through Friday, from 7:30 a.m. to 9 p.m. (except holidays).



**1.** When appropriate and available. If you travel out of state, phone appointments and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state. **2.** Kaiser Permanente 2022 HEDIS® scores. Benchmarks provided by the National Committee for Quality Assurance (NCQA) Quality Compass® and represent all lines of business. Kaiser Permanente combined region scores were provided by the Kaiser Permanente Department of Care and Service Quality. The source for data contained in this publication is Quality Compass 2022 and is used with the permission of NCQA. Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® and HEDIS® are registered trademarks of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. **3.** 2021 Annual Report, Kaiser Permanente, [about.kaiserpermanente.org/who-we-are/annual-reports/2021-annual-report](https://www.kaiserpermanente.org/who-we-are/annual-reports/2021-annual-report). **4.** NCQA's Private Health Insurance Plan Ratings 2022-2023, National Committee for Quality Assurance, 2022: Kaiser Foundation Health Plan of Colorado – HMO (rated 4 out of 5); Kaiser Foundation Health Plan of Georgia, Inc. – HMO (rated 4 out of 5); Kaiser Foundation Health Plan, Inc., of Hawaii – HMO (rated 4 out of 5); Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO (rated 5 out of 5); Kaiser Foundation Health Plan, Inc., of Northern California – HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan of the Northwest – HMO (rated 4 out of 5); Kaiser Foundation Health Plan, Inc., of Southern California – HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan of Washington – HMO (rated 4 out of 5). **5.** See note 7. **6.** Theodore R. Levin, MD, et al., "Effects of Organized Colorectal Cancer Screening on Cancer Incidence and Mortality in a Large, Community-Based Population," *Gastroenterology*, November 2018. **7.** Elizabeth A. McGlynn, PhD, et al., "Measuring Premature Mortality Among Kaiser Permanente Members Compared to the Community," July 20, 2022. **8.** The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time. Some classes vary by location and may require fees. **9.** Calm and myStrength can be used by members 13 and over. The Ginger app and services are not available to any members under 18 years old. **10.** Calm is the number one app for sleep, meditation, and relaxation, with over 100 million downloads and 1.5 million+ 5-star reviews. Learn more at [calm.com/blog/about](https://calm.com/blog/about). **11.** Eligible Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost. **12.** Some of these services may not be covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **13.** For a complete list of services you can use your HSA to pay for, see *Publication 502, Medical and Dental Expenses*, at [irs.gov](https://www.irs.gov). **14.** Kaiser Permanente internal data, 2019; "12 Trends Influencing the Future of Workplace Benefits," Aflac, 2018; U.S. Bureau of Labor Statistics, 2018.

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

In the event of dispute, the provisions of the approved English version of the form will control.

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## HELP IN YOUR LANGUAGE

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

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

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

**Bàsɔ̀̀ Wùd̀̀q̀̀ (Bassa) Dè dɛ nià kɛ dyédé gbo:** ɔ jũ ké m̀̀ Bàsɔ̀̀̀-wùd̀̀q̀̀-po-nyò jũ ní, níí, à wuɖu kà kò d̀̀ò po-poò béìn m̀̀ gbo kpáá. Đá **1-800-777-7902** (TTY: **711**)

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

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

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

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

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

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

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

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

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

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

**日本語 (Japanese) 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902 (TTY: 711)** まで、お電話にてご連絡ください。

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902 (TTY: 711)** 번으로 전화해 주십시오.

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

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

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

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

**Tagalog (Tagalog) PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.  
Tumawag sa **1-800-777-7902 (TTY: 711)**.

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

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

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

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



In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852.