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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** person/**$9,000** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50/visit	Not covered	——————none——————
	Specialist visit	$50/visit	Not covered	——————none——————
	Other practitioner office visit	$50/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$50/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$500/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$25/30-day supply; $50/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. Limited to up to a 30-day supply; or up to a 90-day supply for maintenance drugs. No charge for women's preventive contraceptives.
	Preferred brand drugs	50% coinsurance after deductible	Not covered	
	Non-preferred brand drugs	50% coinsurance after deductible	Not covered	
	Specialty drugs	50% coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	25% coinsurance after deductible	25% coinsurance after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50/visit	$50/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50/visit	Not covered	For individual therapy; Group therapy $25/visit.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$50/visit	Not covered	For individual therapy; Group therapy $25/visit.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	20% coinsurance after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	20% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 20% coinsurance after deductible Outpatient: $50/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$50/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	————————none————————
	Hospice service	20% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$50/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

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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** $2,820
- **Patient pays** $4,720

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	$4,500
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,420
- **Patient pays** $2,980

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
Copays	$1,600
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,980**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** person/**$9,000** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50/visit after deductible	Not covered	——————none——————
	Specialist visit	$50/visit after deductible	Not covered	——————none——————
	Other practitioner office visit	$50/visit after deductible	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$50/visit after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$500/test after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$20/30-day supply; $40/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. Limited to up to a 30-day supply; or up to a 90-day supply for maintenance drugs. No charge for women's preventive contraceptives.
	Preferred brand drugs	$50/30-day supply; $100/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	30% coinsurance after deductible	Not covered	
	Specialty drugs	$50 preferred brand /30-day supply	Not covered	
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	$500/visit after deductible	$500/visit after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	$50/visit after deductible	$50/visit after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day after deductible	Not covered	Copay per day for 4 days; no charge after 4 days.
	Physician/surgeon fee	30% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50/visit after deductible	Not covered	For individual therapy; Group therapy $25/visit after deductible.
	Mental/Behavioral health inpatient services	$500/day after deductible	Not covered	Copay per day for 4 days; no charge after 4 days.
	Substance use disorder outpatient services	$50/visit after deductible	Not covered	For individual therapy; Group therapy $25/visit after deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	$500/day after deductible	Not covered	Copay per day for 4 days; no charge after 4 days.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	$500/day after deductible	Not covered	Copay per day for 4 days; no charge after 4 days.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: $500/ day for 4 days after deductible; Outpatient: $20/ visit after deductible	Not covered	Inpatient: No charge after 4 days. Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$50/visit after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	$250/contract year after deductible	Not covered	Limited to 100 days/ contract year.
	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	$50/visit after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
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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:

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- The insurer stops offering services in the State
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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.**

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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.

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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** $2,840
- **Patient pays** $4,700

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	$4,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $570
- **Patient pays** $4,830

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	$4,500
Copays	$200
Coinsurance	$50
Limits or exclusions	$80
Total	**$4,830**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person/**$10,000** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	30% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	30% coinsurance after deductible	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$20 after deductible /30-day supply; $40 after deductible /31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. Limited to up to a 30-day supply; or up to a 90-day supply for maintenance drugs. No charge for women's preventive contraceptives.
	Preferred brand drugs	30% coinsurance after deductible	Not covered	
	Non-preferred brand drugs	30% coinsurance after deductible	Not covered	
	Specialty drugs	30% coinsurance after deductible	Not covered	
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	30% coinsurance after deductible	30% coinsurance after deductible	——————none——————
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	30% coinsurance after deductible	30% coinsurance after deductible	Non-plan providers are covered only outside the service area.
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	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance after deductible	Not covered	——————none——————
	Mental/Behavioral health inpatient services	30% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	30% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	30% coinsurance after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	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————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	30% coinsurance after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	30% coinsurance after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	30% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	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% coinsurance after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Age 18 and under: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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** $2,840
- **Patient pays** $4,700

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	$4,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $220
- **Patient pays** $5,180

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	$5,000
Copays	$60
Coinsurance	$40
Limits or exclusions	$80
Total	**$5,180**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,750** person/**$3,500** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** person/**$10,000** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	25% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	25% coinsurance after deductible	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	25% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$15 after deductible /30-day supply; $30 after deductible /31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$45 after deductible /30-day supply; $90 after deductible /31 to 90-day supply	Not covered	
	Non-preferred brand drugs	25% after deductible up to 90-day supply	Not covered	
	Specialty drugs	$45 preferred brand after deductible/30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fees	25% coinsurance after deductible	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	25% coinsurance after deductible	25% coinsurance after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge after deductible	No charge after deductible	————————none————————
	Urgent care	25% coinsurance after deductible	25% coinsurance after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fee	25% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance after deductible	Not covered	————————none————————
	Mental/Behavioral health inpatient services	25% coinsurance after deductible	Not covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	25% coinsurance after deductible	Not covered	————————none————————
	Substance use disorder inpatient services	25% coinsurance after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	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	25% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	25% coinsurance after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	25% coinsurance after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	25% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	25% coinsurance after deductible	Not covered	————————none————————
	Hospice service	25% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	25% coinsurance after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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

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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.**

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SPANISH (Español): Para obtener asistencia en Español, llame al 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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** $4,820
- **Patient pays** $2,720

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	$1,800
Copays	$20
Coinsurance	$700
Limits or exclusions	$200
Total	**$2,720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

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	$1,800
Copays	$500
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,680**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,300** person/**$2,600** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** person/**$10,000** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	20% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	20% coinsurance after deductible	Not covered	Chiropractic Care limited to 20 visits/condtion/contract year
	Preventive care/screening/immunization	No charge	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)	20% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$10 after deductible /30-day supply; $20 after deductible /31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$35 after deductible /30-day supply; $70 after deductible /31 to 90-day supply	Not covered	
	Non-preferred brand drugs	20% after deductible up to 90-day supply	Not covered	
	Specialty drugs	$35 preferred brand after deductible/30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	25% coinsurance after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge after deductible	No charge after deductible	————————none————————
	Urgent care	20% coinsurance after deductible	25% coinsurance after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	Not covered	————————none————————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	20% coinsurance after deductible	Not covered	————————none————————
	Substance use disorder inpatient services	20% coinsurance after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	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	20% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	20% coinsurance after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	20% coinsurance after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	————————none————————
	Hospice service	20% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	20% coinsurance after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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:

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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** $5,420
- **Patient pays** $2,120

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	$1,300
Copays	$20
Coinsurance	$600
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,320
- **Patient pays** $2,082

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
Copays	$400
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,080**

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**, **copayments**, and **coinsurance** 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?

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person/**$1,000** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	10% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	10% coinsurance after deductible	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	10% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$5 after deductible /30-day supply; $10 after deductible /31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$10 after deductible /30-day supply; $20 after deductible /31 to 90-day supply	Not covered	
	Non-preferred brand drugs	10% after deductible up to 90-day supply	Not covered	
	Specialty drugs	$10 preferred brand after deductible/30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	10% coinsurance after deductible	25% coinsurance after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge after deductible	No charge after deductible	————————none————————
	Urgent care	10% coinsurance after deductible	25% coinsurance after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fee	10% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance after deductible	Not covered	————————none————————
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	10% coinsurance after deductible	Not covered	————————none————————
	Substance use disorder inpatient services	10% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Prenatal and postnatal care	No charge	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	10% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	10% coinsurance after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	10% coinsurance after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	10% coinsurance after deductible	Not covered	————————none————————
	Hospice service	10% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	10% coinsurance after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

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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** $6,430
- **Patient pays** $1,110

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	$500
Copays	$10
Coinsurance	$400
Limits or exclusions	$200
Total	**$1,110**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,420
- **Patient pays** $980

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	$500
Copays	$200
Coinsurance	$200
Limits or exclusions	$80
Total	**$980**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$200** family Does not apply to Preventive.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	5% coinsurance after deductible	Not covered	——————none——————
	Specialist visit	5% coinsurance after deductible	Not covered	——————none——————
	Other practitioner office visit	5% coinsurance after deductible	Not covered	Chiropractic Care limited to 20 visits/condtion/contract year
	Preventive care/screening/immunization	No charge	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)	5% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	5% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$5 after deductible /30-day supply; $10 after deductible /31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$10 after deductible /30-day supply; $20 after deductible /31 to 90-day supply	Not covered	
	Non-preferred brand drugs	5% after deductible up to 90-day supply	Not covered	
	Specialty drugs	$10 preferred brand after deductible/30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fees	5% coinsurance after deductible	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	5% coinsurance after deductible	25% coinsurance after deductible	Waived if admitted as inpatient.
	Emergency medical transportation	No charge after deductible	No charge after deductible	————————none————————
	Urgent care	5% coinsurance after deductible	25% coinsurance after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance after deductible	Not covered	————————none————————
	Physician/surgeon fee	5% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	5% coinsurance after deductible	Not covered	————————none————————
	Mental/Behavioral health inpatient services	5% coinsurance after deductible	Not covered	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	5% coinsurance after deductible	Not covered	————————none————————
	Substance use disorder inpatient services	5% coinsurance after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	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	5% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	5% coinsurance after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	5% coinsurance after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	5% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	5% coinsurance after deductible	Not covered	————————none————————
	Hospice service	5% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	5% coinsurance after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
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- Infertility treatment
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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:

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

About these Coverage Examples:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,030
- **Patient pays** $510

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	$100
Copays	$10
Coinsurance	$200
Limits or exclusions	$200
Total	**$510**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $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	$100
Copays	$200
Coinsurance	$100
Limits or exclusions	$80
Total	**$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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person/**$5,000** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Not covered	——————none——————
	Specialist visit	$50/visit	Not covered	——————none——————
	Other practitioner office visit	$50/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$300/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$15/30-day supply; $30/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	30% up to 90-day supply	Not covered	
	Specialty drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
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/visit	$400/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50/visit	$50/visit	Non-plan providers are covered only outside the service area.
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	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Mental/Behavioral health inpatient services	30% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Substance use disorder inpatient services	30% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	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————————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 30% coinsurance after deductible Outpatient: $30/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$30/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	30% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	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/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)**

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)**

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Age 18 and under: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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
Copays	$20
Coinsurance	$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
Copays	$1,100
Coinsurance	$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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/**$3,000** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Not covered	——————none——————
	Specialist visit	$50/visit	Not covered	——————none——————
	Other practitioner office visit	$50/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$250/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$15/30-day supply; $30/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	30% up to 90-day supply	Not covered	
	Specialty drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
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	$350/visit	$350/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50/visit	$50/visit	Non-plan providers are covered only outside the service area.
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	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Mental/Behavioral health inpatient services	30% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Substance use disorder inpatient services	30% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	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————————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 30% coinsurance after deductible Outpatient: $30/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$30/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	30% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	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/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

Excluded Services & Other Covered Services:

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- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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Does this Coverage Meet the Minimum Value Standard?

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

About these Coverage Examples:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,920
- **Patient pays** $2,620

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	$1,500
Copays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$2,620**

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
Copays	$1,100
Coinsurance	$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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/**$3,000** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,200** person/**$10,400** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Not covered	——————none——————
	Specialist visit	$50/visit	Not covered	——————none——————
	Other practitioner office visit	$50/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$15/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$250/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$15/30-day supply; $30/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	20% up to 90-day supply	Not covered	
	Specialty drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$350/visit	$350/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$50/visit	$50/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$30/visit	Not covered	For individual therapy; Group therapy $15/visit.
	Substance use disorder inpatient services	20% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	20% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 20% coinsurance after deductible Outpatient: $30/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$30/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	————————none————————
	Hospice service	20% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$30/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Age 18 and under: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

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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** $5,220
- **Patient pays** $2,320

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	$1,500
Copays	$20
Coinsurance	$600
Limits or exclusions	$200
Total	**$2,320**

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
Copays	$1,100
Coinsurance	$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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	——————none——————
	Specialist visit	$25/visit	Not covered	——————none——————
	Other practitioner office visit	$25/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$15/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$150/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$15/30-day supply; $30/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$45/30-day supply; $90/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	20% up to 90-day supply	Not covered	
	Specialty drugs	$45 preferred brand /30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	——————none——————
	Physician/surgeon fees	20% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$20/visit	$20/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	——————none——————
	Physician/surgeon fee	20% coinsurance	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	——————none——————
	Substance use disorder outpatient services	$15/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Substance use disorder inpatient services	20% coinsurance	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	20% coinsurance	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 20% coinsurance; Outpatient: $15/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/ contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$15/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	20% coinsurance	Not covered	————————none————————
	Hospice service	20% coinsurance	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$15/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	Limit of 1 pair/contract year from a select group of frames. Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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- Weight loss programs

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- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
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- Routine Eye Exam (Adult)
- Routine Hearing Tests

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Does this Coverage Meet the Minimum Value Standard?

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

About these Coverage Examples:

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,420
- **Patient pays** $1,120

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	$0
Copays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$1,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

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	$0
Copays	$800
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,180**

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.
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- 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**, **copayments**, and **coinsurance** 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?

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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.

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

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** person/**$4,500** 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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5/visit	Not covered	——————none——————
	Specialist visit	$10/visit	Not covered	——————none——————
	Other practitioner office visit	$10/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$5/visit	Not covered	------———none——————
	Imaging (CT/PET scans, MRIs)	$50/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$5/30-day supply; $10/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$10/30-day supply; $20/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	10% up to 90-day supply	Not covered	
	Specialty drugs	$10 preferred brand/30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	——————none——————
	Physician/surgeon fees	10% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$10/visit	$10/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not covered	——————none——————
	Physician/surgeon fee	10% Coinsurance	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5/visit	Not covered	——————none——————
	Mental/Behavioral health inpatient services	10% Coinsurance	Not covered	——————none——————
	Substance use disorder outpatient services	$5/visit	Not covered	——————none——————
	Substance use disorder inpatient services	10% Coinsurance	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	10% Coinsurance	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 10% Coinsurance; Outpatient: $5/visit	Not covered	Inpatient: No charge after 4 days. Outpatient: PT/OT/ST limited to 30 visits/condition/ contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$5/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	10% Coinsurance	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	10% Coinsurance	Not covered	————————none————————
	Hospice service	10% Coinsurance	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$5/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	Limit of 1 pair/contract year from a select group of frames. Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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** $6,930
- **Patient pays** $610

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	$0
Copays	$10
Coinsurance	$400
Limits or exclusions	$200
Total	**$610**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $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	$0
Copays	$300
Coinsurance	$100
Limits or exclusions	$80
Total	**$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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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**.

- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	——————none——————
	Specialist visit	No charge	Not covered	——————none——————
	Other practitioner office visit	No charge	Not covered	Chiropractic Care limited to 20 visits/condition/ contract year
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	No charge	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. Limited to up to a 30-day supply; or up to a 90-day supply for maintenance drugs.
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	
	Specialty drugs	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	——————none——————
	Physician/surgeon fees	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No charge	No charge	——————none——————
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	No charge	No charge	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	——————none——————
	Physician/surgeon fee	No charge	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	——————none——————
	Mental/Behavioral health inpatient services	No charge	Not covered	——————none——————
	Substance use disorder outpatient services	No charge	Not covered	——————none——————
	Substance use disorder inpatient services	No charge	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————none——————
	Delivery and all inpatient services	No charge	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	No charge	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/ contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	No charge	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	No charge	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	No charge	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	Limit of 1 pair/contract year from a select group of frames. Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Age 18 and under: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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Does this Coverage Provide Minimum Essential Coverage?

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Does this Coverage Meet the Minimum Value Standard?

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NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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** $7,340
- **Patient pays** $200

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	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,320
- **Patient pays** $80

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	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$80**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not covered	——————none——————
	Specialist visit	$40/visit	Not covered	——————none——————
	Other practitioner office visit	$40/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$20/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$150/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$10/30-day supply; $20/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$30/30-day supply; $60/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	20% up to 90-day supply	Not covered	
	Specialty drugs	$30 preferred brand /30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$40/visit	$40/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$20/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Substance use disorder inpatient services	20% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	20% coinsurance after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: 20% coinsurance after deductible Outpatient: $20/visit	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$20/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	————————none————————
	Hospice service	20% coinsurance after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$20/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	1 pair/contract year (select group of frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

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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** $5,620
- **Patient pays** $1,920

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	$0
Copays	$20
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,920**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,930

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	$1,000
Copays	$800
Coinsurance	$50
Limits or exclusions	$80
Total	**$1,930**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not covered	——————none——————
	Specialist visit	$40/visit	Not covered	——————none——————
	Other practitioner office visit	$40/visit	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	$20/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$250/test	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	$10/30-day supply; $20/31 to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	$30/30-day supply; $60/31 to 90-day supply	Not covered	
	Non-preferred brand drugs	30% up to 90-day supply	Not covered	
	Specialty drugs	$30 preferred brand /30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	——————none——————
	Physician/surgeon fees	30% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	Waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$40/visit	$40/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day	Not covered	Copay per day for 4 days; no charge after 4 days.
	Physician/surgeon fee	No charge	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Mental/Behavioral health inpatient services	$500/day	Not covered	Copay per day for 4 days; no charge after 4 days. Copay includes physician/surgeon fees.
	Substance use disorder outpatient services	$20/visit	Not covered	For individual therapy; Group therapy $10/visit.
	Substance use disorder inpatient services	$500/day	Not covered	Copay per day for 4 days; no charge after 4 days. Copay includes physician/surgeon fees.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	$500/day	Not covered	Copay per day for 4 days; no charge after 4 days.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	Inpatient: $500/ day for 4 days; Outpatient: $20/visit	Not covered	Inpatient: No charge after 4 days. Outpatient: PT/OT/ST limited to 30 visits/condition/ contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	$20/visit	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	$250/admission	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	30% coinsurance	Not covered	————————none————————
	Hospice service	30% coinsurance	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	$20/visit	Not covered	Limited to one exam/contract year.
	Glasses	No charge	Not covered	Limit of 1 pair/contract year from a select group of frames. Limited to single vision or bifocal lenses (ST28) Polycarbonate/Plastic. Contacts limited to a 3-month supply from a select list.
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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- Cosmetic surgery
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- Private-duty nursing
- Routine foot care
- 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.)**

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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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:

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- The insurer stops offering services in the State
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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 1-800-492-6116.

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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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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:

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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** $6,840
- **Patient pays** $700

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	$0
Copays	$500
Coinsurance	$ 0
Limits or exclusions	$200
Total	**$700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

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	$0
Copays	$700
Coinsurance	$400
Limits or exclusions	$80
Total	**$1,180**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,350** person/**$12,700** family Does not apply to Preventive. Copays, Rx, Adult Eyeware, 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$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-billed charges, and health care this plan doesn't cover. Adult Eyeware and Adult Dental Services.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, go to www.kp.org or **call 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 855-249-5018, TTY/TDD 1-301-879-6380 or visit us at www.kp.org.
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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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Not covered	No charge for a combined total of 3 primary care or outpatient mental health care visits. Additional visits are no charge after deductible.
	Specialist visit	No charge after deductible	Not covered	——————none——————
	Other practitioner office visit	No charge after deductible	Not covered	Chiropractic Care limited to 20 visits/condition/contract year
	Preventive care/screening/immunization	No charge	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)	No charge after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	No charge after deductible, up to 90-day supply	Not covered	Limited to KP Plan Pharmacy or KP Mail Order. Limited to up to a 30-day supply; or up to a 90-day supply for maintenance drugs. No charge for women's preventive contraceptives.
	Preferred brand drugs	No charge after deductible, up to 90-day supply	Not covered	
	Non-preferred brand drugs	No charge after deductible, up to 90-day supply	Not covered	
	Specialty drugs	No charge after deductible, up to 90-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	——————none——————
	Physician/surgeon fees	No charge after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	No charge after deductible	No charge after deductible	——————none——————
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	No charge after deductible	No charge after deductible	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	——————none——————
	Physician/surgeon fee	No charge after deductible	Not covered	Emergency services covered for non-plan providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	Not covered	——————none——————
	Mental/Behavioral health inpatient services	No charge after deductible	Not covered	No charge for a combined total of 3 primary care or outpatient mental health care visits. Additional visits are no charge after deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	No charge after deductible	Not covered	————————none————————
	Substance use disorder inpatient services	No charge after deductible	Not covered	————————none————————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy for routine global maternity care. Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	No charge after deductible	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Private duty nursing excluded unless authorized by Health Plan.
	Rehabilitation services	No charge after deductible	Not covered	Outpatient: PT/OT/ST limited to 30 visits/condition/contract year. Cardiac Rehab limited to 12 weeks or 36 sessions per episode. Pulmonary Rehab limited to 1 program/lifetime.
	Habilitation services	No charge after deductible	Not covered	Limited to 30 visits/year for adults. No limit for children under age 19.
	Skilled nursing care	No charge after deductible	Not covered	Limited to 100 days/ contract year.
	Durable medical equipment	No charge after deductible	Not covered	————————none————————
	Hospice service	No charge after deductible	Not covered	————————none————————
If your child needs dental or eye care	Eye exam	No charge after deductible	Not covered	Limited to one exam/contract year.
	Glasses	No charge after deductible	Not covered	1 pair/contract year (select group of frames). Limited to single vision or bifocal lenses (ST28) Polycarbonate/ Plastic. Contacts limited to a 3-month supply from a select list.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Dental check-up	Covered per fee schedule	Not covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-ray per yr; 1 set of full mouth x-rays every 5 yrs.

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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-Term/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)

- Bariatric surgery
- Chiropractic Care (20 visits / condition / contract year)
- Hearing aids (Under age 18: 1 per ear per 36 monhts)
- Infertility treatment
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine Hearing Tests

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 1-800-492-6116.

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, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consurmer.HEAU.htm.

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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: □□□□□□□□ 855-249-5018 □ TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 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** $5,620
- **Patient pays** $1,920

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	$0
Copays	$20
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,920**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,930

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	$1,000
Copays	$800
Coinsurance	$50
Limits or exclusions	$80
Total	**$1,930**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call 855-249-5018, 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/healthreform or call 855-249-5018 to request a copy.

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