KAISER PERMANENTE® : **LITHOGRAPHERS & PHOTOENGRAVERS (FLEX 23)**
Kaiser Permanente Insurance Company

Coverage for: Individual / Family | Plan Type: Flex POS

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville. MD 20852
Kaiser Permanente Insurance Company, One Kaiser Plaza, Oakland, CA 94612

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5018 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary or call 1-855-249-5018 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	KP Plan Provider: **$0** Individual / **$0** Family; Participating Provider: **$300** Individual / **$600** Family; Non-Participating Provider: **$600** Individual / **$1,200** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	KP Plan Provider: **$1,500** Individual / **$3,000** Family; Participating Provider: **$3,000** Individual / **$6,000** Family; Non-Participating Provider: **$6,000** Individual / **$12,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, precertification penalties, balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	**Yes.** See www.kp.org or call 1-855-249-5018 (TTY: 711) for a list of network providers.	You pay the least if you use a provider in the Kaiser Permanente network. You pay more if you use a provider in the participating provider network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes** (to be covered at the plan provider level), but 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 a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	$15 / visit, deductible does not apply	30% coinsurance	Copay waived for child under age 5 in Option 1.
	Specialist visit	$20 / visit	$25 / visit, deductible does not apply	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge	No charge, deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRI's)	$50 / test	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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 / prescription at Plan Pharmacy; $10 / prescription at Mail Order	$20 / prescription, deductible does not apply	$20 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Preferred brand drugs	$20 / prescription at Plan Pharmacy; $20 / prescription at Mail Order	$35 / prescription, deductible does not apply	$35 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Non-preferred brand drugs	$35 / prescription at Plan Pharmacy; $35 / prescription at Mail Order	$50 / prescription, deductible does not apply	$50 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Applicable Generic, Preferred, and Non-Preferred copayments, deductible does not apply	Applicable Generic, Preferred, and Non-Preferred copayments, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 / visit	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	Included in facility fee	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$75 / visit	$75 / visit, deductible does not apply	$75 / visit, deductible does not apply	Covered under Option 1; Waived if admitted as inpatient
	Emergency medical transportation	$100 / encounter	$100 / encounter, deductible does not apply	$100 / encounter, deductible does not apply	Covered under Option 1
	Urgent care	$20 / visit	$25 / office visit; 10% coinsurance other services	30% coinsurance	Deductible waived in Option 2 for office visit
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	30% coinsurance	None
	Physician/surgeon fee	Included in facility fee	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / individual visit; $5 / group visit	$15 / individual and group visit, deductible does not apply	30% coinsurance / individual and group visit	Mental/Behavioral health: No coverage for psychological testing for ability, aptitude, intelligence or interest.; Substance abuse: None
	Inpatient services	No charge	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	No charge	No charge, deductible does not apply	30% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in facility fee	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	No charge	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	10% coinsurance	30% coinsurance	Options 2 and 3: combined maximum of 60 visits / year.
	Rehabilitation services	$20 / visit	$25 / visit, deductible does not apply	30% coinsurance	Coverage is limited to Option 1: Outpatient: Limited to 90 consecutive days of treatment/ injury, incident or condition/year. Options 2 and 3: Inpatient: combined maximum of 60 days/ year, Outpatient: combined maximum of 90 visits/year
	Habilitation services	$20 / visit	$25 / visit, deductible does not apply	30% coinsurance	For children under age 21 with congenital or genetic birth defect
	Skilled nursing care	No charge	10% coinsurance	30% coinsurance	Coverage is limited to Option 1: maximum 60 days/year; Options 2 and 3: combined maximum of 40 days/year
	Durable medical equipment	50% coinsurance	50% coinsurance	50% coinsurance	Please refer to your Evidence of Coverage for complete Durable Medical Equipment benefit details.
	Hospice service	No charge	10% coinsurance	30% coinsurance	Coverage is limited to Options 2 and 3: combined maximum of 30 days / year.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	$10 / Optometrist visit; $20 / Ophthalmologist visit	$15 / Optometrist visit; $25 / Ophthalmologist visit, deductible does not apply	30% coinsurance / Optometrist and Ophthalmologist visit	None
	Children's glasses	No charge	Not covered	30% coinsurance	Option 1: 1 pair of glasses / year limited to single or bifocal lenses or 1st purchase of contact lenses / year or 2 pair / eye / year medically necessary contacts (from select group of frames and contacts); Option 3: 1 Pair / year (non designer frames) Limited to single vision or bifocal lenses (ST28) Polycarbonate or Plastic.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for Dental Care

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment (IVF: 3 attempts/lifetime with a lifetime max of $100,000)
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the District of Columbia Healthcare Finance Office of the Ombudsman at 441 4th St, NW (9th and 10th Fl.) Washington, DC 20001, 1-877-685-6391, email healthcareombudsman@dc.gov or http://ombudsman.dc.gov.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-855-249-5018 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
District of Columbia Department of Insurance	1-877-685-6391 or www.disb.dc.gov/

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5018 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5018 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-855-249-5018 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5018 (TTY: 711)

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$90**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$750**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$0**
- **Other (x-ray) copayment** **$0**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Durable medical equipment (*crutches*)
Diagnostic test (*x-ray*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copays	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

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

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

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

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

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

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) **ማስታወሻ:** የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

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

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

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

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

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

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

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

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

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

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

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

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

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

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

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

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

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

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

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

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

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

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

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