Find your healthy place

With care designed to help you thrive

KAISER PERMANENTE®

Welcome to care that fits your life

This Kaiser Permanente for Individuals and Families enrollment guide can help you choose the right health plan for your needs. Here's a look at what you'll get with all of our plans.

Get care on your schedule

Need to schedule an appointment or have a nonurgent question for your doctor's office? Want your prescription refill mailed to your home? After you enroll, create your online account at kp.org or get our mobile app. Then join millions of members who manage their health online – whenever, wherever.

Connect to care from anywhere

Want a convenient, secure way to get care from wherever you are? Schedule a call with a Kaiser Permanente clinician, meet face-to-face online, or email your doctor's office anytime with nonurgent health questions.*†

Many services under one roof

Do more in less time. In most of our facilities, you can see your doctor, get a lab test, and pick up prescriptions – all in a single trip. Find a location near you at **kp.org/facilities**.

Your doctor, your choice

Choose your doctor based on what's important to you. Go to **kp.org/searchdoctors** for details about education, specialties, languages spoken, and more. You can also change doctors at any time.

Discounts for members

Enjoy discounts on products and services that can help you stay healthy – like gym memberships, massage therapy, and more. Explore your options at **kp.org/choosehealthy**.

*When appropriate and available. †These features are available when you get care at Kaiser Permanente facilities.

Choosing your health plan

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

Copay plans – platinum and gold

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

Deductible plans – Gold, Silver, Bronze, Catastrophic

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

HSA-qualified high deductible health plans – silver and bronze

HSA-qualified high deductible health plans (HDHPs) are deductible plans with a special feature. With this plan, you can set up a health savings account (HSA) to pay for health costs like copays, coinsurance, and deductible payments. And you won't pay federal taxes on the money in this account.

You can use your HSA anytime to pay for care, including some services that may not be covered by your plan, like eyeglasses, adult dental care, or chiropractic services.* If you have money left in your HSA at the end of the year, it will roll over for you to use the next year.

*For a complete list of services you can use your HSA to pay for, see Publication 502, Medical and Dental Expenses, at irs.gov.

Example of your costs for care

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

Plan name	Office visit	X-ray	Generic drug
KP VA Gold 0/20/Vision (no deductible)	$20 (waived for children under age 5)	$65	$10*
KP VA Silver 2500/35/Vision ($2,500 deductible)	$35 (waived for children under age 5)	$70	$20*
KP VA Bronze 6000/55/Vision ($6,000 deductible)	First 3 visits $55, then 35% after deductible (copay waived for children under 5)	35% after deductible	$35*

*Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.
The cost estimates above are from **kp.org/treatmentestimates**. Visit this site anytime to get an idea of what the charges for common services might be before you reach your deductible.

Important open enrollment dates for 2021

- The open enrollment period for 2021 coverage runs from November 1, 2020, through December 15, 2020.
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through healthcare.gov.
- For coverage that starts on January 1, 2021, we must receive your Application for Health Coverage and first month's premium no later than December 15, 2020.

Enrolling during a special enrollment period

- Are you getting married, moving to a Kaiser Permanente service area, or losing your health coverage? You can also enroll or change your coverage at other times throughout the year if you have a qualifying life event.
- Visit **kp.org/specialenrollment** for a list of qualifying life events and instructions.

Do you qualify for financial help?

You may be eligible for federal or state financial assistance to help you pay for care or coverage. Visit **healthcare.gov** for details.

Understanding the plans: benefit highlights

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

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

	KP E KP VA Silver 2500/35/Vision
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$8,250/$16,500
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$35 (waived for children under 5)
Specialty care office visit	$55
Most X-rays	$70
Most lab tests	$50
MRI, CT, PET	35% after deductible
Outpatient surgery	35% after deductible
Mental health visit	$35 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	35% after deductible
Emergency and urgent care	
Emergency Department visit	35% after deductible
Urgent care visit	$55
Prescription drugs (up to a 30-day supply)	
Generic	20†
Preferred brand	$60†
Non-preferred brand	35% after $800 pharmacy deductible per member
Specialty	35% after $800 pharmacy deductible per member up to $250 per 30-day prescription
Whole health	
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.

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

KP Offered through Kaiser Permanente

E Offered through the health benefit exchange

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $2,500 for yourself or $5,000 for your family. Then you'd start paying copays or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than $8,250 for yourself and no more than $16,500 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

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

Covered before you reach the deductible

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

Coinsurance

After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 35% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd pay a $55 copay for urgent care visits, whether or not you have met your deductible.

KP Offered through Kaiser Permanente

E Offered through the Health Benefit Exchange

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on healthcare.gov.

	KP E KP VA Bronze 7500/40%/Vision	KP E KP VA Bronze 6900/0%/HSA/ Vision	KP E KP VA Bronze 6000/55/Vision	KP E KP VA Silver 6500/40/Vision	KP E KP VA Silver 5000/40/Vision	KP E KP VA Silver 2500/35/Vision
Plan type	**Deductible**	**HSA-qualified**	**Deductible**	**Deductible**	**Deductible**	**Deductible**
Features						
Annual medical deductible (individual/family)	$7,500/$15,000	$6,900/$13,800	$6,000/$12,000	$6,500/$13,000	$5,000/$10,000	$2,500/$5,000
Annual out-of-pocket maximum (individual/family)	$8,550/$17,100	$6,900/$13,800	$8,550/$17,100	$8,550/$17,100	$8,500/$17,000	$8,250/$16,500
Benefits						
Preventive care						
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)						
Primary care office visit	40% after deductible	No charge after deductible	First 3 visits $55, then 35% after deductible (copay waived for children under 5)	$40 (waived for children under 5)	$40 (waived for children under 5)	$35 (waived for children under 5)
Specialty care office visit	40% after deductible	No charge after deductible	$75 after deductible	$70	$60	$55
Most X-rays	40% after deductible	No charge after deductible	35% after deductible	35% after deductible	$70	$70
Most lab tests	40% after deductible	No charge after deductible	$75	35% after deductible	$50	$50
MRI, CT, PET	40% after deductible	No charge after deductible	$625 after deductible	35% after deductible	35% after deductible	35% after deductible
Outpatient surgery	40% after deductible	No charge after deductible	35% after deductible	35% after deductible	35% after deductible	35% after deductible
Mental health visit	40% after deductible	No charge after deductible	$55 (individual therapy)	$40 (individual therapy)	$40 (individual therapy)	$35 (individual therapy)
Inpatient hospital care						
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	No charge after deductible	35% after deductible	35% after deductible	35% after deductible	35% after deductible
Maternity						
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	No charge after deductible	35% after deductible	35% after deductible	35% after deductible	35% after deductible
Emergency and urgent care						
Emergency Department visit	40% after deductible	No charge after deductible	35% after deductible	35% after deductible	35% after deductible	35% after deductible
Urgent care visit	40% after deductible	No charge after deductible	$75 after deductible	$70	$60	$55
Prescription drugs (up to a 30-day supply)						
Generic	40% after deductible	No charge after deductible	$35†	$30†	$30†	$20†
Preferred brand	40% after deductible	No charge after deductible	$100 after $1,000 pharmacy deductible per member†	$65†	$60†	$60†
Non-preferred brand	50% after deductible	No charge after deductible	50% after $1,000 pharmacy deductible per member	50% after deductible	50% after deductible	35% after $800 pharmacy deductible per member
Specialty	50% after deductible up to $250 maximum per 30-day prescription	No charge after deductible	50% after $1,000 pharmacy deductible per member up to $250 maximum per 30-day prescription	50% after deductible up to $250 maximum per 30-day prescription	50% after deductible up to $250 maximum per 30-day prescription	35% after $800 pharmacy deductible per member up to $250 maximum per 30-day prescription
Whole health						
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.					

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Membership Agreement and Evidence of Coverage* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Membership Agreement and Evidence of Coverage*, please visit **kp.org/plandocuments**, call us at **1-800-777-7902**, or contact your broker. For services subject to the deductible, you will have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

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

KP Offered through Kaiser Permanente

E Offered through the Health Benefit Exchange

Financial assistance options are available for certain plans, and for Native Alaskans and American Indians on healthcare.gov.

	KP E KP VA Gold 1700/25/Vision	KP E KP VA Gold 1250/20/Vision	KP E KP VA Gold 0/20/Vision	KP E KP VA Platinum 0/15/Vision	KP E KP VA Catastrophic‡ 8550/0/Vision
Plan type	**Deductible**	**Deductible**	**Copayment**	**Copayment**	**Deductible**
Features					
Annual medical deductible (individual/family)	$1,700/$3,400	$1,250/$2,500	None/None	None/None	$8,550/$17,100
Annual out-of-pocket maximum (individual/family)	$8,550/$17,100	$7,500/$15,000	$6,950/$13,900	$4,000/$8,000	$8,550/$17,100
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	$25 (waived for children under 5)	$20 (waived for children under 5)	$20 (waived for children under 5)	$15 (waived for children under 5)	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	$60	$40	$40	$20	No charge after deductible
Most X-rays	30% after deductible	$65	$65	$20	No charge after deductible
Most lab tests	30% after deductible	$30	$30	$20	No charge after deductible
MRI, CT, PET	30% after deductible	35% after deductible	$500	$250	No charge after deductible
Outpatient surgery	30% after deductible	35% after deductible	35%	$350	No charge after deductible
Mental health visit	$25 (individual therapy)	$20 (individual therapy)	$20 (individual therapy)	$15 (individual therapy)	First 3 office visits no charge.** Additional visits no charge after deductible.
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	35% after deductible	35%	$350 per day up to 4 days*	No charge after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	35% after deductible	35%	$350 per day up to 4 days*	No charge after deductible
Emergency and urgent care					
Emergency Department visit	30% after deductible	35% after deductible	$500 (waived if admitted)	$300 (waived if admitted)	No charge after deductible
Urgent care visit	$60	$40	$40	$20	No charge after deductible
Prescription drugs (up to a 30-day supply)					
Generic	$15†	$10†	$10†	$5†	No charge after deductible
Preferred brand	$60†	$55 after $200 pharmacy deductible per member†	$55†	$35†	No charge after deductible
Non-preferred brand	50% after deductible	35% after $200 pharmacy deductible per member	35% after $150 pharmacy deductible per member	$55†	No charge after deductible
Specialty	50% after deductible up to $250 maximum per 30-day prescription	35% after $200 pharmacy deductible per member up to $250 maximum per 30-day prescription	35% after $150 pharmacy deductible per member up to $250 maximum per 30-day prescription	$150†	No charge after deductible
Whole health					
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.				

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*After 4 days, there is no charge for covered services related to the admission.

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

‡Only applicants under age 30, or applicants age 30 and older who provide a certificate from the health benefit exchange in Virginia demonstrating hardship or lack of affordable coverage, may purchase a KP VA Catastrophic 8550/0/Vision plan.

**The KP VA Catastrophic 8550/0/Vision plan includes 3 office visits at no charge before your deductible applies. Office visits include primary care or outpatient mental health office visits.

E Offered through the Health Benefit Exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through healthcare.gov.

	E KP VA Silver 3000/40/CSR/Vision (6500)	E KP VA Silver 700/15/CSR/Vision (6500)	E KP VA Silver 100/5/CSR/Vision (6500)
Plan type	**Deductible**	**Deductible**	**Deductible**
Features			
Annual medical deductible (individual/family)	$3,000/$6,000	$700/$1,400	$100/$200
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000	$2,700/$5,400	$2,000/$4,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$40 (waived for children under 5)	$15 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$70	$40	$20
Most X-rays	30% after deductible	20% after deductible	10% after deductible
Most lab tests	30% after deductible	20% after deductible	10% after deductible
MRI, CT, PET	30% after deductible	20% after deductible	10% after deductible
Outpatient surgery	30% after deductible	20% after deductible	10% after deductible
Mental health visit	$40 (individual therapy)	$15 (individual therapy)	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	20% after deductible	10% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	10% after deductible
Emergency and urgent care			
Emergency Department visit	30% after deductible	20% after deductible	10% after deductible
Urgent care visit	$70	$40	$20
Prescription drugs (up to a 30-day supply)			
Generic	$30†	$20†	$5†
Preferred brand	$65†	$40†	$15†
Non-preferred brand	50% after deductible	50% after deductible	50% after deductible
Specialty	50% after deductible up to $250 maximum per 30-day prescription	50% after deductible up to $250 maximum per 30-day prescription	50% after deductible up to $250 maximum per 30-day prescription
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.		

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

E Offered through the Health Benefit Exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through healthcare.gov.

	E KP VA Silver 3500/35/CSR/Vision (5000)	E KP VA Silver 0/15/CSR/Vision (5000)	E KP VA Silver 0/5/CSR/Vision (5000)
Plan type	**Deductible**	**Copayment**	**Copayment**
Features			
Annual medical deductible (individual/family)	$3,500/$7,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000	$2,700/$5,400	$2,000/$4,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$35 (waived for children under 5)	$15 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$55	$40	$15
Most X-rays	$55	$40	$15
Most lab tests	$40	$40	$10
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	$35 (individual therapy)	$15 (individual therapy)	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%
Emergency and urgent care			
Emergency Department visit	35% after deductible	30%	10%
Urgent care visit	$55	$40	$15
Prescription drugs (up to a 30-day supply)			
Generic	$25†	$15†	$5†
Preferred brand	$60†	$60†	$15†
Non-preferred brand	35% after deductible	30%	10%
Specialty	35% after deductible up to $250 maximum per 30-day prescription	30% up to $250 maximum per 30-day prescription	10% up to $250 maximum per 30-day prescription
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.		

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

E Offered through the Health Benefit Exchange

Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through healthcare.gov.

	E KP VA Silver 2200/30/CSR/Vision (2500)	E KP VA Silver 0/10/CSR/Vision (2500)	E KP VA Silver 0/5/CSR/Vision (2500)
Plan type	**Deductible**	**Copayment**	**Copayment**
Features			
Annual medical deductible (individual/family)	$2,200/$4,400	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000	$2,700/$5,400	$1,800/$3,600
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$30 (waived for children under 5)	$10 (waived for children under 5)	$5 (waived for children under 5)
Specialty care office visit	$55	$40	$15
Most X-rays	$70	$40	$20
Most lab tests	$45	$40	$5
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	$30 (individual therapy)	$10 (individual therapy)	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%
Emergency and urgent care			
Emergency Department visit	35% after deductible	30%	10%
Urgent care visit	$55	$40	$15
Prescription drugs (up to a 30-day supply)			
Generic	$20†	$10†	$5†
Preferred brand	$60†	$60†	$10†
Non-preferred brand	35% after $800 pharmacy deductible per member	30% after $50 pharmacy deductible per member	10%
Specialty	35% after $800 pharmacy deductible per member up to $250 maximum per 30-day prescription	30% after $50 pharmacy deductible per member up to $250 maximum per 30-day prescription	20% up to $250 maximum per 30-day prescription
Whole health			
Healthy services	Vision exams are included with your plan. Visit our Optical Centers for your glasses & contacts. Visit **kp2020.org** for more information. Explore our broad range of self-care resources designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare** for more details.		

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

Find your rate

Use the monthly rates chart on the following pages or apply on **buykp.org/apply** to have your rate calculated automatically. Along with your monthly rate, consider what you'll need to pay when you get care.

How is your rate determined?

Your rate is based on:

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

Interested in a family plan?

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

Family members include:

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

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

The rates in the monthly rates chart apply to these ZIP codes. Please check that your ZIP code is listed below. If it isn't, call us at **1-800-494-5314** for information on other rate areas.

ZIP codes for Virginia

20101–05	20175–78	22081–82	22225–27	22534–35
20108–13	20180–82	22095–96	22230	22538
20115	20184	22101–03	22240–46	22544–47
20116	20185	22106–09	22301–15	22551
20117–22	20186	22116	22320	22553–56
20124	20187	22118–19	22331–34	22565
20128	20188	22121–22	22350	22567
20129	20189–92	22124–25	22401–08	22580
20131–32	20194–97	22134–35	22412	22639
20134–37†	20198	22150–53	22430	22642
20138	20598	22156	22443	22643
20139	22003	22158–61	22446	22720
20140	22009	22172	22448	22728
20141–43	22015	22180–83	22451	22736
20144	22025–27	22185	22463	22739
20146–49	22030–44	22191–95	22471	22960†
20151–53	22046	22199	22481	23015
20155–56	22060	22201–07	22485	23024
20158–60	22066–67	22209–17	22508	23117†
20163–72	22079	22219	22526	23170

†Portions of ZIP code not in service area: 20135, 22960, and 23117.

2021 Monthly rates

Please note: These rates do not include the federal financial assistance you may be eligible to receive through healthcare.gov.

Age on 2021 effective date	KP VA Bronze 6000/55/Vision	KP VA Bronze 6900/0%/HSA/Vision	KP VA Bronze 7500/40%/Vision	KP VA Silver 2500/35/Vision	KP VA Silver 5000/40/Vision	KP VA Silver 6500/40/Vision	KP VA Gold 0/20/Vision
0-14	$250.10	$251.82	$238.86	$284.93	$276.32	$271.84	$316.38
15	272.33	274.20	260.09	310.26	300.88	296.00	344.50
16	280.83	282.76	268.21	319.94	310.27	305.24	355.25
17	289.33	291.32	276.33	329.63	319.67	314.48	366.00
18	298.48	300.53	285.07	340.06	329.78	324.43	377.58
19	307.64	309.75	293.81	350.49	339.89	334.38	389.16
20	317.12	319.29	302.87	361.29	350.37	344.68	401.16
21	326.92	329.17	312.23	372.46	361.20	355.34	413.56
22	326.92	329.17	312.23	372.46	361.20	355.34	413.56
23	326.92	329.17	312.23	372.46	361.20	355.34	413.56
24	326.92	329.17	312.23	372.46	361.20	355.34	413.56
25	328.23	330.49	313.48	373.95	362.65	356.76	415.22
26	334.77	337.07	319.73	381.40	369.87	363.87	423.49
27	342.62	344.97	327.22	390.34	378.54	372.40	433.42
28	355.37	357.81	339.40	404.87	392.63	386.26	449.54
29	365.83	368.34	349.39	416.79	404.19	397.63	462.78
30	371.06	373.61	354.38	422.74	409.97	403.31	469.40
31	378.91	381.51	361.88	431.68	418.64	411.84	479.32
32	386.75	389.41	369.37	440.62	427.30	420.37	489.25
33	391.66	394.35	374.05	446.21	432.72	425.70	495.45
34	396.89	399.61	379.05	452.17	438.50	431.39	502.07
35	399.50	402.25	381.55	455.15	441.39	434.23	505.38
36	402.12	404.88	384.05	458.13	444.28	437.07	508.68
37	404.73	407.51	386.54	461.11	447.17	439.91	511.99
38	407.35	410.15	389.04	464.09	450.06	442.76	515.30
39	412.58	415.41	394.04	470.05	455.84	448.44	521.92
40	417.81	420.68	399.03	476.01	461.62	454.13	528.54
41	425.66	428.58	406.53	484.95	470.29	462.66	538.46
42	433.17	436.15	413.71	493.51	478.60	470.83	547.97
43	443.64	446.68	423.70	505.43	490.15	482.20	561.21
44	456.71	459.85	436.19	520.33	504.60	496.41	577.75
45	472.08	475.32	450.86	537.84	521.58	513.11	597.19
46	490.39	493.76	468.35	558.69	541.81	533.01	620.35
47	510.98	514.49	488.02	582.16	564.56	555.40	646.40
48	534.52	538.19	510.50	608.98	590.57	580.98	676.18
49	557.73	561.56	532.67	635.42	616.21	606.21	705.54
50	583.89	587.90	557.65	665.22	645.11	634.64	738.63
51	609.71	613.90	582.31	694.64	673.65	662.71	771.30
52	638.16	642.54	609.48	727.05	705.07	693.63	807.28
53	666.93	671.51	636.95	759.82	736.86	724.90	843.67
54	697.98	702.78	666.62	795.21	771.17	758.66	882.96
55	729.04	734.05	696.28	830.59	805.49	792.41	922.25
56	762.71	767.95	728.44	868.95	842.69	829.01	964.85
57	796.71	802.19	760.91	907.69	880.25	865.97	1,007.86
58	833.00	838.73	795.57	949.03	920.35	905.41	1,053.76
59	850.98	856.83	812.74	969.52	940.21	924.96	1,076.51
60	887.27	893.37	847.40	1,010.86	980.31	964.40	1,122.41
61	918.66	924.97	877.37	1,046.62	1,014.98	998.51	1,162.12
62	939.25	945.71	897.04	1,070.08	1,037.74	1,020.90	1,188.17
63	965.08	971.71	921.71	1,099.51	1,066.28	1,048.97	1,220.84
64+	980.76	987.51	936.69	1,117.38	1,083.60	1,066.02	1,240.68

Rates are effective January 1, 2021, through December 31, 2021.

2021 Monthly rates

Please note: These rates do not include the federal financial assistance you may be eligible to receive through healthcare.gov.

Age on 2021 effective date	KP VA Gold 1250/20/Vision	KP VA Gold 1700/25/Vision	KP VA Platinum 0/15/Vision	KP VA Catastrophic 8550/0/Vision	KP VA Silver 2500/35/Vision	KP VA Silver 5000/40/Vision	KP VA Silver 6500/40/Vision
0-14	$310.07	$303.25	$365.58	$173.77	$331.17	$321.16	$315.95
15	337.63	330.20	398.07	189.22	360.61	349.71	344.03
16	348.17	340.51	410.50	195.12	371.86	360.62	354.77
17	358.71	350.81	422.92	201.03	383.12	371.54	365.51
18	370.06	361.91	436.30	207.39	395.24	383.29	377.07
19	381.41	373.01	449.69	213.75	407.36	395.05	388.64
20	393.16	384.51	463.54	220.34	419.92	407.22	400.61
21	405.32	396.40	477.88	227.15	432.90	419.82	413.00
22	405.32	396.40	477.88	227.15	432.90	419.82	413.00
23	405.32	396.40	477.88	227.15	432.90	419.82	413.00
24	405.32	396.40	477.88	227.15	432.90	419.82	413.00
25	406.94	397.98	479.79	228.06	434.63	421.50	414.66
26	415.05	405.91	489.35	232.60	443.29	429.89	422.92
27	424.78	415.43	500.82	238.06	453.68	439.97	432.83
28	440.59	430.89	519.46	246.91	470.56	456.34	448.94
29	453.56	443.57	534.75	254.18	484.42	469.78	462.15
30	460.04	449.91	542.39	257.82	491.34	476.49	468.76
31	469.77	459.43	553.86	263.27	501.73	486.57	478.67
32	479.50	468.94	565.33	268.72	512.12	496.64	488.58
33	485.58	474.89	572.50	272.13	518.62	502.94	494.78
34	492.06	481.23	580.15	275.76	525.54	509.66	501.39
35	495.30	484.40	583.97	277.58	529.01	513.02	504.69
36	498.55	487.57	587.79	279.40	532.47	516.38	508.00
37	501.79	490.74	591.62	281.21	535.93	519.73	511.30
38	505.03	493.91	595.44	283.03	539.40	523.09	514.60
39	511.52	500.26	603.09	286.67	546.32	529.81	521.21
40	518.00	506.60	610.73	290.30	553.25	536.53	527.82
41	527.73	516.11	622.20	295.75	563.64	546.60	537.73
42	537.05	525.23	633.19	300.98	573.60	556.26	547.23
43	550.02	537.91	648.48	308.25	587.45	569.69	560.45
44	566.24	553.77	667.60	317.33	604.76	586.49	576.97
45	585.29	572.40	690.06	328.01	625.11	606.22	596.38
46	607.98	594.60	716.82	340.73	649.35	629.73	619.51
47	633.52	619.57	746.93	355.04	676.63	656.17	645.53
48	662.70	648.11	781.33	371.39	707.79	686.40	675.26
49	691.48	676.26	815.26	387.52	738.53	716.21	704.59
50	723.91	707.97	853.49	405.69	773.16	749.79	737.63
51	755.93	739.28	891.25	423.64	807.36	782.96	770.25
52	791.19	773.77	932.82	443.40	845.02	819.48	806.18
53	826.86	808.65	974.88	463.39	883.12	856.43	842.53
54	865.36	846.31	1,020.27	484.97	924.25	896.31	881.76
55	903.87	883.97	1,065.67	506.55	965.37	936.19	921.00
56	945.62	924.80	1,114.90	529.95	1,009.96	979.43	963.54
57	987.77	966.02	1,164.59	553.57	1,054.98	1,023.10	1,006.49
58	1,032.76	1,010.02	1,217.64	578.78	1,103.03	1,069.70	1,052.34
59	1,055.06	1,031.83	1,243.92	591.28	1,126.84	1,092.79	1,075.05
60	1,100.05	1,075.83	1,296.97	616.49	1,174.90	1,139.38	1,120.89
61	1,138.96	1,113.88	1,342.84	638.30	1,216.45	1,179.69	1,160.54
62	1,164.49	1,138.85	1,372.95	652.61	1,243.73	1,206.14	1,186.56
63	1,196.51	1,170.17	1,410.70	670.55	1,277.93	1,239.30	1,219.19
64+	1,215.96	1,189.20	1,433.64	681.45	1,298.70	1,259.45	1,239.00

Rates are effective January 1, 2021, through December 31, 2021.

2021 Monthly rates

Please note: These rates do not include the federal financial assistance you may be eligible to receive through healthcare.gov.

Age on 2021 effective date	KP VA Silver 3000/40/CSR/Vision (6500) KP VA Silver 700/15/CSR/Vision (6500) KP VA Silver 100/5/CSR/Vision (6500)	KP VA Silver 3500/35/CSR/Vision (5000) KP VA Silver 0/15/CSR/Vision (5000) KP VA Silver 0/5/CSR/Vision (5000)	KP VA Silver 2200/30/CSR/Vision (2500) KP VA Silver 0/10/CSR/Vision (2500) KP VA Silver 0/5/CSR/Vision (2500)
0-14	$315.95	$321.16	$331.17
15	344.03	349.71	360.61
16	354.77	360.62	371.86
17	365.51	371.54	383.12
18	377.07	383.29	395.24
19	388.64	395.05	407.36
20	400.61	407.22	419.92
21	413.00	419.82	432.90
22	413.00	419.82	432.90
23	413.00	419.82	432.90
24	413.00	419.82	432.90
25	414.66	421.50	434.63
26	422.92	429.89	443.29
27	432.83	439.97	453.68
28	448.94	456.34	470.56
29	462.15	469.78	484.42
30	468.76	476.49	491.34
31	478.67	486.57	501.73
32	488.58	496.64	512.12
33	494.78	502.94	518.62
34	501.39	509.66	525.54
35	504.69	513.02	529.01
36	508.00	516.38	532.47
37	511.30	519.73	535.93
38	514.60	523.09	539.40
39	521.21	529.81	546.32
40	527.82	536.53	553.25
41	537.73	546.60	563.64
42	547.23	556.26	573.60
43	560.45	569.69	587.45
44	576.97	586.49	604.76
45	596.38	606.22	625.11
46	619.51	629.73	649.35
47	645.53	656.17	676.63
48	675.26	686.40	707.79
49	704.59	716.21	738.53
50	737.63	749.79	773.16
51	770.25	782.96	807.36
52	806.18	819.48	845.02
53	842.53	856.43	883.12
54	881.76	896.31	924.25
55	921.00	936.19	965.37
56	963.54	979.43	1,009.96
57	1,006.49	1,023.10	1,054.98
58	1,052.34	1,069.70	1,103.03
59	1,075.05	1,092.79	1,126.84
60	1,120.89	1,139.38	1,174.90
61	1,160.54	1,179.69	1,216.45
62	1,186.56	1,206.14	1,243.73
63	1,219.19	1,239.30	1,277.93
64+	1,239.00	1,259.45	1,298.70

Rates are effective January 1, 2021, through December 31, 2021.

Learn about vision and dental coverage

With our Kaiser Permanente Individuals and Families dental plans and vision coverage, you get the benefits you need and the quality care you've come to expect. There's no waiting period — you can start receiving covered services the minute your coverage takes effect.

Essential vision care

You can get optometry services like routine eye exams, glaucoma screenings, and cataract screenings without a referral from your personal physician. You'll need a referral to get care from an ophthalmologist. Many Kaiser Permanente medical centers have a vision center where you can have exams and purchase quality eyewear and contact lenses. To locate a medical center with a vision center, and find information about other vision benefits, visit **kp2020.org**.

For information about vision coverage and limitations:

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

Refer to your *Membership Agreement and Evidence of Coverage*.

Register at **kp.org** and read a summary of your benefits online.

Adult dental benefits

For an additional premium of $12.99 per month, adults 19 and older can choose to enroll in an enhanced dental plan that offers orthodontic coverage and a $10 copay for most preventive care procedures. To enroll, select the option on your application to enhance your dental coverage with the dental HMO rider.

Choosing a dentist

You may choose any general dentist from the list of participating dental providers. Specialty care is also available. To see a participating specialist, you'll need a referral from a participating general dentist. These dentists are conveniently located throughout the community.

To locate a participating provider, please visit **dominiondental.com/kaiserdentists** or call Dominion at **1-855-733-7524.**

Important details and notices

Notice of insurance information practices – abbreviated version

Virginia

Please be advised that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter Kaiser Permanente), has not received any personal information regarding your application from any person other than the applicant. Personal information necessary to determine eligibility for coverage may be collected from the application.

Please also be assured that it is Kaiser Permanente's policy to protect the confidentiality of your private medical information to the full extent of the law.

Kaiser Permanente will not disclose any personal or privileged information about an individual that is collected or received unless the disclosure is:

- Authorized in writing by the individual; or
- Made to a medical care institution or medical professional for the purpose of:
  - Verifying insurance coverage or benefits, or
  - Informing an individual of a medical problem of which the individual may not be aware, or
  - Conducting an operations or services audit, provided that information is disclosed only as is reasonably necessary to accomplish the foregoing purposes; or
- Made to an insurance regulatory authority; or
- Made to a law enforcement or other government authority to protect Kaiser Permanente interests in preventing or prosecuting the perpetration of fraud upon it; or
- As permitted by applicable law.

You have the right to see and obtain copies of the recorded personal information pertaining to you by submitting a written request. If you ask us to correct, amend, or delete any information about you in our files and if we refuse to do so, you have the right to give us a concise statement of what you believe is the correct information and we will put your statement in our file so that anyone reviewing it will see it.

Information obtained from a report prepared by an insurance-support organization may be retained by an insurance-support organization and disclosed to other persons.

This is an abbreviated version of the notice of information collection and disclosure practices. Kaiser Permanente's complete *Notice of Insurance Information Practices* form is available to you upon request.

Benefits, Exclusions, and Limitations

Medical Exclusions

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

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

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

The following services are excluded from coverage:

1. **Alternative Medical Services**
   - a. Acupuncture
   - b. Holistic medicine
   - c. Homeopathic medicine
   - d. Hypnosis
   - e. Aroma therapy
   - f. Massage and massage therapy
   - g. Reiki therapy
   - h. Herbal, vitamin or dietary products or therapies
   - i. Naturopathy
   - j. Thermography
   - k. Orthomolecular therapy
   - l. Contact reflex analysis
   - m. Bioenergial synchronization technique (BEST)
   - n. Iridology-study of the iris
   - o. Auditory integration therapy (AIT)
   - p. Colonic irrigation
   - q. Magnetic innervation therapy
   - r. Electromagnetic therapy
   - s. Neurofeedback/Biofeedback.

2. **Certain Exams and Services**

   Physical examinations and other services:
   - a. Required for obtaining or maintaining employment or participation in employee programs;
   - b. Required for insurance, licensing, or disability determination; or
   - c. On court-order or required for parole or probation.

3. **Cosmetic Services**

   Cosmetic services, including surgery or related Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of cosmetic services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.

4. **Court Ordered Testing**

   Court ordered testing or care unless medically necessary.

5. **Custodial Care**

   Custodial care means assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine, or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to custodial care received while under hospice care.

6. **Dental Care**

   Dental care and dental x-rays, including dental appliances, dental implants, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction

syndrome. This exclusion does not apply to medically necessary dental care.

7. **Disposable Supplies**

   Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages.

8. **Durable Medical Equipment,** except for equipment that we would specifically cover.

9. **Employer or Government Responsibility**

   Financial responsibility for services that an employer or government agency is required by law to provide.

10. **Experimental or Investigational Services**

    A service is experimental or investigational for your condition if any of the following statements apply to it at the time the service is or will be provided to you:

    a. It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or

    b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or

    c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

    d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In determining whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

a. Your medical records;

b. The written protocols or other documents pursuant to which the service has been or will be provided;

c. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service;

d. The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;

e. The published authoritative medical or scientific literature regarding the service, as applied to your illness or injury; and

f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

We will consult with our Medical Group and then use the criteria described above to decide if a particular service is experimental or investigational.

11. **Family Members**

    Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse or domestic partner, child, brother, sister, parent, in-law, or self.

12. **Health Club Memberships and Fitness Services**

    Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even when ordered by a plan provider. This exclusion also applies to health spas.

13. **Prosthetic and Orthotic Devices**

    Prosthetics for sports or cosmetic purposes. Services and supplies for external prosthetic and orthotic devices.

14. **Routine Foot Care Services,** except for patients| with diabetes or vascular disease.

15. **Travel and Lodging Expenses,** except that in some situations if a Plan Physician refers you to a non-Plan Provider outside our Service Area, we may pay certain expenses that we pre-authorize in

accord with our travel and lodging guidelines; or if travel and lodging expenses are incurred as part of transplant services.

16. **Vein Treatment**

    Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

17. **Workers' Compensation or Employer's Liability**

    Financial responsibility for services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered services from the following sources:

    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or

    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

Medical Limitations

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

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

In the event that we are unable to provide the services, we, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente's Medical Group Plan Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a member in procuring the services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some members may refuse to accept services recommended by their plan physician for a particular condition. If you refuse to accept services recommended by your plan physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another plan physician.

Pharmacy Exclusions

We do not cover:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a plan provider and are listed in our Preferred Drug List;
2. Compounded preparations that do not contain at least one (1) ingredient requiring a prescription and are not listed in our Preferred Drug List;
3. Take home drugs received from a hospital, skilled nursing facility or other similar facility;
4. Drugs that are considered to be experimental or investigational;
5. Drugs that can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., the same active ingredient and dosage) to a prescription drug, unless otherwise prohibited by state or federal laws governing Essential Health Benefits;
6. Drugs for which the member is not legally obligated to pay or for which no charge is made;
7. Drugs or dermatological preparations, ointments, lotions and creams prescribed for cosmetic purposes including, but not limited to, drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss;
8. Medical foods;
9. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a member participating in our hospice care program;

10. Prescribed drugs and accessories that are necessary for services that we do not cover;
11. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from our standard packaging for prescription drugs;
12. Alternative formulations or delivery methods that are different from our standard formulation or delivery method for prescription drugs and deemed not medically necessary;
13. Drugs and devices that are provided during a covered stay in a hospital or skilled nursing facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug;
14. Bandages or dressings;
15. Diabetic equipment and supplies;
16. Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a plan physician, pursuant to clinical guidelines for adults;
17. Immunizations and vaccinations solely for the purpose of travel;
18. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee. The determination by the Pharmacy and Therapeutics Committee is subject to appeal if the prescribing physician believes the over-the-counter therapeutically equivalent drug is inappropriate therapy for treatment of the patient's condition;
19. Drugs for weight management;
20. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.

Pharmacy Limitations

For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a plan pharmacy, unless the criteria for coverage of non-preferred brand drugs has been met.

In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with our emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable cost share per prescription will apply. However, a member may file a claim for the difference between the cost share for a full prescription and the pro-rata cost share for the actual amount received.

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

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

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

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

1. the prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member; and
2. the member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs.

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

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

prescription or change in a prescription. The day supply is based on the:

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

For contraceptives, members may obtain up to a twelve (12)-month supply of prescription contraceptives in a single prescription, when authorized by the prescribing plan provider or a referral physician.

Dental Exclusions

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

1. Services which are covered under worker's compensation or employer's liability laws;
2. Services which are not necessary for the patient's dental health as determined by us;
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by us;
4. Oral surgery requiring the setting of fractures or dislocations;
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of us, such services should not be performed in a dental office;
6. Dispensing of drugs;
7. Hospitalization for any dental procedure;
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation;
9. Replacement due to loss or theft of prosthetic appliance;
10. Procedures not listed as covered benefits;
11. Services obtained outside of the dental office that are not preauthorized, with the exception of out-of-area emergencies;
12. Services related to the treatment of Temporomandibular Disorder (TMD) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires medically necessary orthodontia services;
13. Services performed by a participating specialist without a referral from a participating general dentist, with the exception of orthodontics;
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by us. The prophylactic removal of these teeth for medically necessary orthodontia services may be covered subject to review;
15. Non-medically necessary orthodontia and Phase I Treatment for medically necessary orthodontia are not covered benefits. Discounts are provided to members through our agreements with our participating orthodontists. These provider agreements create no liability for payment by us and payments by the member for these services do not contribute to the out-of-pocket maximum. The Invisalign system and similar specialized braces are not a covered benefit.

Dental Limitations

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

1. One (1) evaluation per six (6) months, per patient. Coverage for oral evaluations begins with the eruption of the first tooth;
2. One (1) teeth cleaning is covered per six (6) months, per patient;
3. One (1) fluoride treatment is covered per six (6) months, per patient;
4. One (1) sealant per tooth, per lifetime, per patient, limited to occlusal surfaces of posterior permanent teeth without restorations or decay;
5. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime;
6. One (1) space maintainer is covered per twelve (12) months, per quadrant (unilateral) or per arch (bilateral), per patient;

7. One (1) distal shoe space maintainer, fixed, unilateral per lifetime;
8. Replacement of a filling is covered if it is more than twelve (12) months from the date of original placement. Fillings are covered once per tooth per surface per twelve (12) months;
9. Replacement of a crown, denture (fixed or removable), onlay (porcelain/ceramic) or labial veneer is covered if it is more than five (5) years from the date of original placement. One (1) per tooth per five (5) years;
10. Replacement of a primary stainless-steel crown is covered if it is more than three (3) years from the date of original placement, per tooth, per patient;
11. Crown and bridge copayments apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%;
12. Relining and rebasing of dentures is covered once per twenty-four (24) months, per patient, only after six (6) months of initial placement;
13. Root canal treatment is covered once per tooth, per lifetime, per patient. Retreatment of root canal is covered once per tooth, per lifetime, per patient, not within twenty-four (24) months, when done by the same provider/location;
14. Periodontal scaling and root planing and osseous surgery are limited to one (1) per twenty-four (24) months, per quadrant, per patient. Gingivectomy or gingivoplasty are limited to one (1) per patient per lifetime;
15. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu or a covered cleaning, limited to once per two (2) years;
16. Full mouth debridement is covered once per twelve (12) months, per patient;
17. One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years;
18. Localized delivery of antimicrobial agents is limited to one (1) benefit per tooth for three (3) teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per twelve (12) months, per patient. Must have pocket depths of five (5) millimeters or greater;
19. Periodontal surgery of any type, including any associated material, is covered once every twenty-four (24) months, per quadrant or surgical site, per patient;
20. Periodontal maintenance after active therapy is covered four (4) times per twelve (12) months, per patient;
21. Coronectomy, intentional partial tooth removal, one (1) per lifetime;
22. Frenulectomy, one (1) per patient per lifetime;
23. All dental services that are to be rendered in a hospital setting require coordination and approval from both the dental insurer and the medical insurer before services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes;
24. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of sixty (60) minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation;
25. Occlusal guard, by report, for grinding and clenching of teeth;
26. Apexification, apicoectomy, retrograde fillings and clinical crown lengthening are each covered once per patient, per lifetime;
27. Orthodontics is only covered if medically necessary as determined by us. Orthodontics is covered for members up until the attainment of age nineteen (19) years. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility;
28. Synchronous teledentistry or asynchronous teledentistry are limited to two (2) per calendar year.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (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 **1-800-632-9700** (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 at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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 **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (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。**1-800-632-9700**（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. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (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 **1-800-632-9700** (TTY: **711**).

Notes

Notes

Helpful online resources

Have questions about getting started with Kaiser Permanente? Want to learn more about our services? Use this information to explore the resources available to members, or to get answers to any questions you have.

Discover Kaiser Permanente ..... kp.org/thrive

Enrollment resources

Apply online ..... buykp.org/apply

Get started if you're a new member ..... kp.org/newmember

Enroll during a special enrollment period ..... kp.org/specialenrollment

Member resources

Manage your care ..... kp.org

Find a location near you ..... kp.org/facilities

Choose your doctor ..... kp.org/searchdoctors

Create your online account ..... kp.org/registernow

Get an idea of what your care will cost ..... kp.org/treatmentestimates

Get an estimate of what you'll pay for your care ..... kp.org/costestimates

Get a copy of your *Evidence of Coverage* ..... kp.org/plandocuments

Additional resources

Find resources for healthier living ..... kp.org/healthyliving

Get in touch with us by phone

Get general information about Kaiser Permanente 1-800-494-5314

The right choice for a healthier you

Having a good health plan is important. So is getting quality care.
With Kaiser Permanente, you get both.

Want to learn more?

Visit **kp.org** or call us at **1-800-494-5314** (TTY **711**).

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of the Mid-Atlantic States, Inc.
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