KAISER PERMANENTE®: **KP DC Bronze Added Choice 6500/55/POS/Vision**
Coverage for: Individual / Family | **Plan Type:** POS SIG

2101 East Jefferson Street, Rockville, MD 20852

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 https://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?	Plan Provider: **$6,500** Individual / **$13,000** Family; Non-Plan Provider: **$13,000** Individual / **$26,000** 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 the deductibles for specific services.
What is the out-of-pocket limit for this plan?	Plan Provider: **$8,700** Individual / **$17,400** Family; Non-Plan Provider: **$17,100** Individual / **$34,200** 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?	Copayments on certain services, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
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.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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 Non-Plan 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	$55 / visit, deductible does not apply	40% coinsurance	Copayment waived for children under age 5
	Specialist visit	$80 / visit, deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% 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)	X-ray: $200 visit; Lab $80 / visit	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$500 / test	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan 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 (Tier 1)	$35 / prescription at Plan Pharmacy and Mail Order, deductible does not apply; $45 / prescription at Participating Pharmacy, deductible does not apply	40% coinsurance	Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies. Plan Provider: up to a 90-day supply for 1.5 copays through Mail Order. Plan Provider: No charge, deductible does not apply for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Preferred brand drugs (Tier 2)	$100 / prescription at Plan Pharmacy and Mail Order; $110 / prescription at Participating Pharmacy	40% coinsurance	Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies. Plan Provider: up to a 90-day supply for 1.5 copays through Mail Order. Plan Provider: No charge, deductible does not apply for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Non-preferred drugs (Tier 3)	50% coinsurance / prescription at Plan Pharmacy and Mail Order; 50% coinsurance / prescription at Participating Pharmacy	40% coinsurance	Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan and Participating Pharmacies. Plan Provider: up to a 90-day supply for 1.5 copays through Mail Order. Plan Provider: No charge, deductible does not apply for preventive drugs, contraceptives, or oral chemotherapy drugs.
	Specialty drugs (Tier 4)	50% coinsurance / prescription at Plan Pharmacy and Mail Order; 50% coinsurance / prescription at Participating Pharmacy	40% coinsurance	Up to a $150 max per 30-day supply or up to a $300 max per 90-day supply. Plan Provider: No charge deductible does not apply for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 / visit	40% coinsurance	None
	Physician/surgeon fees	$80 / visit	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 / visit	$500 / visit	Non-Plan Provider: Covered In-Plan Copayment waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	Non-Plan Provider: Covered In-Plan
	Urgent care	$80 / visit, deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3.
	Physician/surgeon fees	$80 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$55 / individual visit, deductible does not apply; $27 / group visit, deductible does not apply	40% coinsurance	None
	Inpatient services	$500 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3.
If you are pregnant	Office visits	No charge, deductible does not apply	40% 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	$80 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3.
	Childbirth/delivery facility services	$500 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3.
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	None
	Rehabilitation services	$80 / visit	40% coinsurance	Outpatient: Cardiac Rehab is limited to 90 consecutive days.
	Habilitation services	$80 / visit	40% coinsurance	None
	Skilled nursing care	$300 / day	40% coinsurance	Copay per day for 3 days; no charge after day 3. Coverage is limited to 60 days / year.
	Durable medical equipment	No charge	40% coinsurance	None
	Hospice services	No charge	40% coinsurance	Coverage is limited to 180 days / eligibility period.
If your child needs dental or eye care	Children's eye exam	$55 / Optometrist visit, deductible does not apply; $80 / Ophthalmologist visit, deductible does not apply	40% coinsurance	Coverage limited to one exam/year.
	Children's glasses	No charge, deductible does not apply	40% coinsurance	Plan Provider: 1 pair of glasses / year or 1st purchase of contact lenses / year or 2 pair / eye / year medically necessary contacts (from select group of frames and contacts); Non-Plan Provider: 1 pair / year (non-designer frames)
	Children's dental check-up	No charge, deductible does not apply	Not covered	Discount fees apply to other services. $10 office visit copay applies / visit.

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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- 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
- Chiropractic Care
- 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, Securities and Banking	202-727-8000 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 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	$6500
Specialist copayment	$80
Hospital (facility) copayment	$500
Other (blood work) copayment	$80

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

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

The plan's overall deductible	$6500
Specialist copayment	$80
Hospital (facility) copayment	$500
Other (blood work) copayment	$80

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,100**

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

The plan's overall deductible	$6500
Specialist copayment	$80
Hospital (facility) copayment	$500
Other (x-ray) copayment	$200

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is**	**$2,800**

**Note: The Patient Pays amount is capped at the plan's out-of-pocket limit. Total amounts may not add up due to rounding.

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