

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 12/01/2020-11/30/2021

 **KAISER PERMANENTE®** : **POWERRIDE MOTORSPORTS (FLEX H wRx C)**
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 : \$500 Individual / \$1,000 Family; Non-Participating Provider : \$1,000 Individual / \$2,000 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 deductibles for specific services.
What is the out-of-pocket limit for this plan ?	KP Plan Provider : \$2,250 Individual / \$4,500 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	\$30 / visit	\$45 / visit, deductible does not apply	40% coinsurance	Copay waived for child under age 5 in Option 1.
	Specialist visit	\$40 / visit	\$55 / visit, deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRI's)	\$100 / test	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000 / year.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary .	Generic drugs	\$10 / prescription at Plan Pharmacy ; \$10 / prescription at Mail Order	\$25 / prescription, deductible does not apply	\$30 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies ; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
	Preferred brand drugs	\$30 / prescription at Plan Pharmacy ; \$30 / prescription at Mail Order	\$50 / prescription, deductible does not apply	\$55 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies ; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
	Non-preferred brand drugs	\$55 / prescription at Plan Pharmacy ; \$55 / prescription at Mail Order	\$75 / prescription, deductible does not apply	\$75 / prescription, deductible does not apply	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies ; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
	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 3 copays at Plan and Participating Pharmacies ; Up to a 90-day supply for 2 copays through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 / visit	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000 / year.
	Physician/surgeon fees	Included in facility fee	20% coinsurance	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 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	\$100 / visit	\$100 / visit, deductible does not apply	\$100 / 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	\$40 / visit	\$55 / office visit; 20% coinsurance other services	40% coinsurance	Deductible waived in Option 2 for office visit
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / admission	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000 / year.
	Physician/surgeon fee	Included in facility fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / individual visit; \$15 / group visit	\$45 / individual and group visit, deductible does not apply	40% coinsurance / individual and group visit	Mental/Behavioral health: No coverage for psychological testing for ability, aptitude, intelligence or interest; Substance abuse: None
	Inpatient services	\$100 / admission	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000 / year.
If you are pregnant	Office visits	No charge	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	Included in facility fee	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	\$100 / admission	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000 / 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 you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	40% coinsurance	Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000/year. Limited to 60 visits combined/year.
	Rehabilitation services	\$40 / visit	\$55 / visit, deductible does not apply	40% coinsurance	Coverage is limited to Option 1: Outpatient: Limited to 30 visits of PT/OT/ST / year / injury / incident / condition. Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000/year. Inpatient: combined maximum of 60 days/year, Outpatient: combined maximum of 90 visits/year.
	Habilitation services	\$40 / visit	\$55 / visit, deductible does not apply	40% coinsurance	For children under age 3.
	Skilled nursing care	\$100 / admission	20% coinsurance	40% coinsurance	Coverage is limited to Option 1: maximum 60 days/year; Options 2 and 3: Precertification required. Failure to precertify may results in a penalty of 30% up to \$5000/year. Combined maximum of 40 days/year.
	Durable medical equipment	No charge	50% coinsurance	50% coinsurance	None
	Hospice service	No charge	20% coinsurance	40% coinsurance	Coverage is limited to Options 2 and 3: Precertification required. Failure to precertify may result in a penalty of 30% up to \$5000/year. Combined maximum of 180 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	\$30 / Optometrist visit; \$40 / Ophthalmologist visit	\$45 / Optometrist visit; \$55 / Ophthalmologist visit, deductible does not apply	40% coinsurance / Optometrist and Ophthalmologist visit	None
	Children's glasses	No charge	Not covered	40% 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 .)		
• Cosmetic surgery • Dental care (Adult)	• 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.)		
• Acupuncture (20 visit limit/year) • Bariatric surgery • Chiropractic care (20 visit limit/year)	• Hearing aids (1/ear/36 months with a max benefit of \$1,000) • Infertility treatment	• 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 agencies in the chart below.

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
Virginia Department of Insurance	1-877-310-6560 or www.scc.virginia.gov/boi

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, kwijigo 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$40	■ Specialist copayment	\$40	■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100	■ Hospital (facility) copayment	\$100
■ Other (blood work) copayment	\$0	■ Other (blood work) copayment	\$0	■ Other (x-ray) copayment	\$0
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$100	Copayments	\$900	Copayments	\$400
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$160	The total Joe would pay is	\$960	The total Mia would pay is	\$400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. 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 Permanente Insurance Company 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: KPIC Civil Rights Coordinator, Grievance 1557, 5855 Copley Drive, Suite 250, San Diego, CA 92111, telephone number 1-888-251-7052.

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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

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

Bàsɔ̀wò Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo: Ɔ jũ ké m̀ Bàsɔ̀wò-wùdù-po-nyò jũ ní, níf, à wuɖu kà kò dò po-poò béìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় 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.

فارسی

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 નિઃશુલ્ક 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, dijiri gi. Kpọọ **1-800-777-7902** (TTY: 711).

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

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

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

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

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

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

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

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

ไทย (Thai) เรียน: หากคุณพูดภาษาไทย 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).