⚠️ **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, contact 1-855-505-0462. 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.com or call 1-855-505-0462 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Annual $100 Individual / $200 Family**	You must pay all of the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to seen when the deductible starts over (usually, but not always January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	**Yes**	Preventive care services do not require you to meet the deductible.
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?	**Medical: $600/IND; $1,200 FAM Rx: $5,800IND/ $11,600 FAM**	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, balance-billing 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.** For a list of preferred providers, visit www.carefirst.com or call **1-800-367-3387.**	This plan uses a preferred provider network. You will pay the most if you use a non-preferred 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?	**No.**	You can see the specialist you choose without a referral. You will pay less if you choose a preferred provider 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		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	**Out-of-Network Provider** (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Specialist visit	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Preventive care/screening/ immunization	$0	$0 up to allowed amount	Immunizations as recommended by the Department of Health & Human Services
If you have a test	Diagnostic test (x-ray, blood work)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Imaging (CT/PET scans, MRIs)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$15 copay retail $30 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	Preferred brand drugs	$35 copay retail $70 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	Non-preferred brand drugs	$50 copay retail $100 copay mail order	N/A	Retail up to a 30 day supply; 31-90 day supply mandatory mail order
	Specialty drugs	Varies by drug – see above copays	N/A	Limited list of injectable drugs. Contact Optum @ **1-800-788-4863**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Physician/surgeon fees	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need immediate medical attention	Emergency room care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Covered ONLY for accidental injury within 48 hours or life-threatening illness within 12 hours of onset of illness
	Emergency medical transportation	20% up to $2,500, $0 thereafter	$20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Urgent care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you have a hospital stay	Facility fee (e.g., hospital room)	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required** – call **Conifer Health Solutions @ 1-866-308-7335.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	**Out-of-Network Provider** (You will pay the most)	
	Physician/surgeon fees	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Inpatient services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required** – call **Conifer Health Solutions @ 1-866-308-7335.**
If you are pregnant	Office visits	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Pre-natal care only for dependent children.** Charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Members and spouses only**. Charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	**Members and spouses only**. Charges above allowed amount are your responsibility.
If you need help recovering or have other special health needs	Home health care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Rehabilitation services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Annual limit of 50 visits combined for PT / OT / Speech therapy and Chiropractic Treatment
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Durable medical equipment	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Charges above allowed amount are your responsibility
	Hospice services	20% up to $2,500, $0 thereafter	20% up to $2,500, $0 thereafter	Pre-authorization **required** – call **Conifer Health Solutions @ 1-866-308-7335**
If your child needs dental or eye care	Children's eye exam	$0	$0 up to allowed amount	Charges above allowed amount are your responsibility
	Children's glasses	$10 copay	$130 allowance single vision	
	Children's dental check-up	$0 up to allowed amount	Amount above plan allowance	Charges above allowed amount are your responsibility

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.)		
• Bariatric Surgery – unless Medically Necessary • Cosmetic Surgery • Dental Care (separate plan) • Habilitation services	• Infertility treatment • Long-term care	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Hearing aids – Minor Children 21 years of age or younger	• Non-emergency care outside U.S.	• Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-505-0462. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www,dol.gov/ebsa/healthreform. 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 plan at 1-888-494-4443. For more information about your rights, this notice, or assistance, contact the plan at 443-573-3632 or 1-866-621-7974. You may also contact the U.S. Department of Labor, Benefits Security Administration (1-866-444-3272 or www.dol.gov/ebsa) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or www.cciio.cms.gov)

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

────────────────*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	Managing Joe's type 2 Diabetes	Mia's Simple Fracture
(9 months of in-network pre-natal care and a hospital delivery)	(a year of routine in-network care of a well-controlled condition)	(in-network emergency room visit and follow up care)

Peg is Having a Baby

- The plan's overall deductible — $100
- Specialist [cost sharing] — 20%
- Hospital (facility) [cost sharing] — 20%
- Other [cost sharing] — 20%

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	$12,100

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

Managing Joe's type 2 Diabetes

- The plan's overall deductible — $100
- Specialist [cost sharing] — 20%
- Hospital (facility) [cost sharing] — 20%
- Other [cost sharing] — $15

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	$5,000

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$260
Coinsurance	$240
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$655**

Mia's Simple Fracture

- The plan's overall deductible — $100
- Specialist [cost sharing] — 20%
- Hospital (facility) [cost sharing] — 20%
- Other [cost sharing] — 20%

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	$2,200

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$485**

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

KAISER PERMANENTE® : **Plumbers and Steamfitters Local 486**

Coverage for: Individual / Family | Plan Type: HMO

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 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 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	$1,000 Individual / $2,000 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, 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.
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, 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.

SBC ID:22527

⚠️	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	$5 / visit	Not covered	None
	Specialist visit	$10 / visit	Not covered	None
	Preventive care/ screening/ immunization	No charge	Not covered	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	Not covered	None
	Imaging (CT/PET scans, MRI's)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Most generic drugs (Tier 1)	No charge / prescription at Plan Pharmacy and Mail Order $15 / prescription at Participating Pharmacy.	Not covered	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Most preferred brand name drugs (Tier 2)	$25 / prescription at Plan Pharmacy and Mail Order. $35 / prescription at Participating Pharmacy.	Not covered	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Non-preferred drugs (Tier 3)	$50 / prescription at Plan Pharmacy and Mail Order. $60 / prescription at Participating Pharmacy.	Not covered	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Specialty drugs (Tier 4)	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	Up to a 30-day supply; Up to a 90-day supply for 2 copays. No charge for oral chemotherapy drugs.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 / visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	Waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$10 / visit	Not covered	Non-plan providers are covered only outside the service area: $10 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	No charge	Not covered	Emergency services covered for non-plan providers
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral health: $10 / individual visit. $5 / group visit.; Substance abuse: $5 / individual visit. $10 / group visit.	Not covered	Mental/Behavioral health: No coverage for psychological and neuropsychological testing, for ability, aptitude, intelligence, or interest; Substance abuse: None
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	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	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	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 help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$10 / visit	Not covered	Outpatient: Limited to 30 visits of PT/OT/ST / year / injury / incident / condition
	Habilitation services	$10 / visit	Not covered	For children until the end of the month in which the child turns age 19
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days / year
	Durable medical equipment	No charge	Not covered	None
	Hospice service	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$5 / Optometrist visit. $10 / Ophthalmologist visit.	Not covered	None
	Children's glasses	No charge	Not covered	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)
	Children's dental check-up	Not covered	Not covered	No coverage for Dental Care

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • 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.)		
• Bariatric surgery • Chiropractic care (30 visit limit/year)	• Hearing aids (For children to the end of the month of age 19: 1/ear/36 months) • Infertility treatment (IVF: 3 attempts/live birth with a lifetime max of $100,000)	• Routine eye care (Adult) • Weight loss programs

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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
Maryland Insurance Administration	1-877-261-8807 or www.insurance.maryland.gov

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		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	$10	■ Specialist copayment	$10	■ Specialist copayment	$10
■ Hospital (facility) copayment	$0	■ Hospital (facility) copayment	$0	■ Hospital (facility) copayment	$0
■ Other (blood work) copayment	$0	■ Other (blood work) copayment	$0	■ Other (x-ray) copayment	$0

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

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*)

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	$12,100
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Total Example Cost	$5,000
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$400**

Total Example Cost	$2,200
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

NONDISCRIMINATION NOTICE

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

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:

  ☐ Qualified sign language interpreters

  ☐ Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:

  ☐ Qualified interpreters

  ☐ Information written in other languages

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

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

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

HELP IN YOUR LANGUAGE

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

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

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **117**.(:TTY)   **1-800-777-7902**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

اردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **117**.(: TTY) **1-800-777-7902**

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**).