



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 <https://kp.org/plandocuments> or call 1-888-865-5813 (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/](http://www.healthcare.gov/sbc-glossary/) or call 1-888-865-5813 (TTY: 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$3,700 Individual / \$7,400 Family                                                                                                     | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.                                                | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,800 Individual / \$19,600 Family                                                                                                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-888-865-5813 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers                                                              | Why this Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes, but you may self-refer to certain <a href="#">specialists</a> . | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |

 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<br>(You will pay the least) | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                       |
|------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness         | \$50 / visit, <a href="#">deductible</a> does not apply     | Not covered                                                    | None                                                                                                                                                                                                                        |
|                                                                        | <a href="#">Specialist</a> visit                         | \$80 / visit, <a href="#">deductible</a> does not apply     | Not covered                                                    | None                                                                                                                                                                                                                        |
|                                                                        | <a href="#">Preventive care/ screening/ immunization</a> | No charge, <a href="#">deductible</a> does not apply        | Not covered                                                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)      | 35% <a href="#">coinsurance</a>                             | Not covered                                                    | None                                                                                                                                                                                                                        |
|                                                                        | Imaging (CT/PET scans, MRI's)                            | \$550 / scan                                                | Not covered                                                    | None                                                                                                                                                                                                                        |

| Common Medical Event                                                                                                                                                                                            | Services You May Need                          | What You Will Pay Plan Provider<br>(You will pay the least)                                                                                                                                                                                                                                                    | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs                                  | \$20 / <a href="#">prescription</a> (retail), <a href="#">deductible</a> does not apply. \$40 / <a href="#">prescription</a> (mail order), <a href="#">deductible</a> does not apply. \$30 / <a href="#">prescription</a> ( <a href="#">network</a> pharmacies), <a href="#">deductible</a> does not apply.    | Not covered                                                    | Up to a 30-day supply (retail); Up to 90-day supply (mail order). <a href="#">Network</a> Pharmacies limited to one time fill. No charge for contraceptives (subject to <a href="#">formulary</a> guidelines).                  |
|                                                                                                                                                                                                                 | Preferred brand drugs                          | \$70 / <a href="#">prescription</a> (retail), <a href="#">deductible</a> does not apply. \$140 / <a href="#">prescription</a> (mail order), <a href="#">deductible</a> does not apply. \$90 / <a href="#">prescription</a> ( <a href="#">network</a> pharmacies), <a href="#">deductible</a> does not apply.   | Not covered                                                    | Up to a 30-day supply (retail); Up to 90-day supply (mail order). <a href="#">Network</a> Pharmacies limited to one time fill.                                                                                                  |
|                                                                                                                                                                                                                 | Non-preferred brand drugs                      | \$120 / <a href="#">prescription</a> (retail), <a href="#">deductible</a> does not apply. \$240 / <a href="#">prescription</a> (mail order), <a href="#">deductible</a> does not apply. \$150 / <a href="#">prescription</a> ( <a href="#">network</a> pharmacies), <a href="#">deductible</a> does not apply. | Not covered                                                    | Up to a 30-day supply (retail); Up to 90-day supply (mail order). <a href="#">Network</a> Pharmacies limited to one time fill.                                                                                                  |
|                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a>                | 35% <a href="#">coinsurance</a> / <a href="#">prescription</a> (retail), <a href="#">deductible</a> does not apply. 45% <a href="#">coinsurance</a> / <a href="#">prescription</a> ( <a href="#">network</a> pharmacies), <a href="#">deductible</a> does not apply.                                           | Not covered                                                    | Up to a 30-day supply (retail & <a href="#">network</a> pharmacies). <a href="#">Network</a> Pharmacies limited to one-time fill. Subject to <a href="#">formulary</a> guidelines, when approved through the exception process. |
| <b>If you have outpatient surgery</b>                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center) | 35% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                | Not covered                                                    | None                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                 | Physician/surgeon fees                         | 35% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                | Not covered                                                    | None                                                                                                                                                                                                                            |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay Plan Provider<br>(You will pay the least)                                                                        | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                 |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 35% <a href="#">coinsurance</a>                                                                                                    | 35% <a href="#">coinsurance</a>                                | None                                                                                                                                                                                  |
|                                                                           | <a href="#">Emergency medical transportation</a> | 35% <a href="#">coinsurance</a>                                                                                                    | 35% <a href="#">coinsurance</a>                                | None                                                                                                                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | \$100 / visit, <a href="#">deductible</a> does not apply                                                                           | Not covered                                                    | <a href="#">Non-Plan providers</a> covered when temporarily outside of the service area: \$100 / visit, <a href="#">deductible</a> does not apply.                                    |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | None                                                                                                                                                                                  |
|                                                                           | Physician/surgeon fee                            | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | None                                                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$50 / individual visit, <a href="#">deductible</a> does not apply. \$25 / group visit, <a href="#">deductible</a> does not apply. | Not covered                                                    | None                                                                                                                                                                                  |
|                                                                           | Inpatient services                               | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | None                                                                                                                                                                                  |
| If you are pregnant                                                       | Office visits                                    | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                           | Childbirth/delivery professional services        | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | None                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services            | 35% <a href="#">coinsurance</a>                                                                                                    | Not covered                                                    | None                                                                                                                                                                                  |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay Plan Provider<br>(You will pay the least)                                                        | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                        |
|-----------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge, <a href="#">deductible</a> does not apply                                                               | Not covered                                                    | Coverage is limited to 120 visits / year.                                                                                                                                    |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$80 / visit (outpatient), <a href="#">deductible</a> does not apply. 35% <a href="#">coinsurance</a> (inpatient). | Not covered                                                    | Coverage is limited to 40 outpatient visits/ therapy/ year combined for Occupational and Physical therapy. Speech therapy is limited to 40 outpatient visits/ therapy/ year. |
|                                                                       | <a href="#">Habilitation services</a>     | \$80 / visit (outpatient), <a href="#">deductible</a> does not apply. 35% <a href="#">coinsurance</a> (inpatient). | Not covered                                                    | Coverage is limited to 40 outpatient visits/ therapy/ year combined for Occupational and Physical therapy. Speech therapy is limited to 40 outpatient visits/ therapy/ year. |
|                                                                       | <a href="#">Skilled nursing care</a>      | 35% <a href="#">coinsurance</a>                                                                                    | Not covered                                                    | Coverage is limited to 150 days / year                                                                                                                                       |
|                                                                       | <a href="#">Durable medical equipment</a> | 35% <a href="#">coinsurance</a>                                                                                    | Not covered                                                    | Prior authorization required.                                                                                                                                                |
|                                                                       | <a href="#">Hospice service</a>           | No charge, <a href="#">deductible</a> does not apply                                                               | Not covered                                                    | None                                                                                                                                                                         |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | \$50 / visit for refractive exam, <a href="#">deductible</a> does not apply                                        | Not covered                                                    | Coverage is limited to one exam / year                                                                                                                                       |
|                                                                       | Children's glasses                        | No charge, <a href="#">deductible</a> does not apply                                                               | Not covered                                                    | Coverage is limited to one pair of lenses & collection frames or contact lenses / year for children up to age 18.                                                            |
|                                                                       | Children's dental check-up                | Not covered                                                                                                        | Not covered                                                    | None                                                                                                                                                                         |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                                           |                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>                                           | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

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

- Chiropractic care (20 visit limit / year: Spinal Manipulation only)
- Routine eye care (Adult)

**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](http://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                                                            | 1-888-865-5813 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>     |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| Georgia Department of Insurance                                                              | 1-800-656-2298 or <a href="http://www.oci.ga.gov/">www.oci.ga.gov/</a>                                    |

**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 1-888-865-5813 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-865-5813 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-865-5813 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-865-5813 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-865-5813 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-865-5813 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-865-5813 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-888-865-5813 (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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 35%     |

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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$3,700         |
| <a href="#">Copayments</a>             | \$10            |
| <a href="#">Coinsurance</a>            | \$3,100         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$50            |
| <b>The total Peg would pay is</b>      | <b>\$6,860</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 35%     |

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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$100          |
| <a href="#">Copayments</a>             | \$2,100        |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$2,200</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$80    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%     |
| ■ Other (x-ray) <a href="#">coinsurance</a>                     | 35%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$2,200        |
| <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,600</b> |

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



# NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille, and accessible electronic formats
- Provides 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 **1-888-865-5813** (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: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: **1-888-865-5813**.

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>.

This notice is available at <https://healthy.kaiserpermanente.org/georgia/language-assistance/nondiscrimination-notice>

## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-888-865-5813** (TTY: 711).

**አማርኛ (Amharic) ትኩረት:** አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-888-865-5813** ይደውሉ (TTY: 711)።

**العربية (Arabic) تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-888-865-5813** (TTY: 711).

**中文 (Chinese) 注意事項:** 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-888-865-5813** (TTY: 711)。

**فارسی (Farsi) توجه:** اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-888-865-5813** تماس بگیرید (TTY (تلفن متنی): **711**).

**Français (French) ATTENTION:** si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-888-865-5813** (TTY: 711).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-888-865-5813** an (TTY: 711).

**ગુજરાતી (Gujarati) ધ્યાન આપો:** જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-888-865-5813** (TTY: 711) પર કોલ કરો.

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-888-865-5813** (TTY: 711).

**हिन्दी (Hindi) ध्यान दें:** अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ्त उपलब्ध हैं। **1-888-865-5813** (TTY: 711) पर कॉल करें।

**日本語 (Japanese) 注意:** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-888-865-5813** までお電話ください (TTY : 711)。

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-888-865-5813**로 전화해 주세요 (TTY: 711).

**Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN:** Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódílnih **1-888-865-5813** (TTY: 711).

**Português (Portuguese) ATENÇÃO:** Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-888-865-5813** (TTY: 711).

**Русский (Russian) ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-888-865-5813** (TTY: 711).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-888-865-5813** (TTY: **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-888-865-5813** (TTY: **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-888-865-5813** (TTY: **711**).

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