

Healthy together

Care and coverage that fits your life



Welcome to care that fits your life



*When appropriate and available.

†These features are available when you get care at Kaiser Permanente facilities.

The right choice for your health

Welcome to your Kaiser Permanente for Individuals and Families enrollment guide. This guide will help you select the right health plan for your needs.

Simple steps to apply

Use this guide to help you find a plan that works for you. Then, apply online or fill out a paper application.

- Choose your health plan** 3
- Find your rate** 11
- Learn about dental and vision coverage** 14
- Find a facility near you** 15



Visit buykp.org/apply to compare plans, see if you qualify for federal financial assistance, calculate your rate, or apply online.

Important deadline for open enrollment

The open enrollment period for 2019 coverage runs from **November 1, 2018, through December 15, 2018**. You can change or apply for coverage through Kaiser Permanente, or we can help you apply through the Health Insurance Marketplace.

For coverage that starts on January 1, 2019, we must receive your Application for Health Coverage and first month’s premium **no later than December 15, 2018**.

Enrolling during a special enrollment period

Are you getting married, having a baby, or losing your health coverage? You may also enroll or change your coverage throughout the year if you have a qualifying life event.

Visit kp.org/specialeenrollment for a list of qualifying life events and instructions.

Your care, your way

Get care where, when, and how you want it. With more options to choose from, it's easier to stay on top of your health.

Choose how you connect to care



Online

Stay on top of your care at **kp.org**. Once you're registered, you can view your medical record, refill most prescriptions, schedule routine appointments, and more. Email your doctor's office anytime with nonurgent questions. You'll usually get a response within 2 business days.



Video

Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face online. Call us or email your doctor's office to see if video visits are available to you.



Phone

Have a condition that doesn't require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente doctor.



In person

Most of our locations have many services under one roof, so you can see your doctor, get lab services or X-rays, and pick up a prescription – all in the same trip.



Online wellness tools

Visit **kp.org/healthyliving** for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs.



Discounts for members

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

Some features are available only when you get care at Kaiser Permanente facilities.

*All video appointments are for certain medical conditions and for members who are age 18 or older. Routine video visit appointments are with physicians who practice at Kaiser Permanente facilities. During a routine video visit with your doctor, you must be present in Maryland, Virginia, or Washington, D.C. For urgent video visits with a doctor, you may also be located in Florida, North Carolina, West Virginia, or Pennsylvania (available weekdays from 10 a.m. to 10 p.m. and weekends from noon to midnight, Eastern time).

Choose your health plan

Understanding health plans

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

Copay plans

Platinum, Gold

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

Deductible plans

Gold, Silver, Bronze

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

HSA-qualified deductible plans

Silver

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

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

*For a complete list of services you can use your HSA to pay for, see Publication 502, *Medical and Dental Expenses*, at [irs.gov](https://www.irs.gov).

Choosing a plan based on your care needs

If you need a lot of care, you may want a plan with a higher monthly rate so that you pay less when you come in for care. If you don't go to the doctor much, you may want a plan with a lower monthly rate, keeping in mind you'll pay more if and when you do get care.

Monthly rate versus out-of-pocket costs

Plan level	What you pay for your monthly rate	What you pay when you get care (Emergency Department visit, lab test, etc.)
Platinum		
Gold		
Silver		
Bronze		

An example of costs when you get care

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

Plan name	Office visit	X-ray	Generic drug
KP VA Gold 0/20/Dental (No deductible)	\$20 (waived for children under 5)	\$40	\$10*
KP VA Silver 2500/30/Dental (\$2,500 deductible)	\$30 (waived for children under 5)	\$50	\$15*
KP VA Bronze 5500/50 Dental (\$5,500 deductible)	3 visits \$50, then \$50 after deductible* (copay waived for children under 5)	\$110	\$25*

The cost estimates above are from our estimate tools website, kp.org/treatmentestimates. Visit this site anytime to get an idea of what the charges for common services might be before you meet your deductible.

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

†Includes 3 primary office visits at \$50 before your deductible applies.

Understanding the plans: benefit highlights

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

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

	KP M KP VA Silver 2500/30/Dental
Plan type	Deductible
Features	
Annual medical deductible (individual/family)	\$2,500/\$5,000
Annual out-of-pocket maximum (individual/family)	\$7,750/\$15,500
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	\$30 (waived for children under 5)
Specialty care office visit	\$50
Most X-rays	\$50
Most lab tests	\$30
MRI, CT, PET	35% after deductible
Outpatient surgery	35% after deductible
Mental health visit	\$30 (individual therapy)
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	35% after deductible
Emergency and urgent care	
Emergency Department visit	35% after deductible
Urgent care visit	\$50
Prescription drugs (up to a 30-day supply)	
Generic	\$15*
Preferred brand	\$55 after \$750 pharmacy deductible per member*
Non-preferred brand	35% after \$750 pharmacy deductible per member
Specialty	35% after \$750 pharmacy deductible per member up to \$250 maximum per 30-day prescription
Whole health	
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

KP Offered through Kaiser Permanente
M Offered through the Health Insurance Marketplace

Annual deductible

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

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than \$7,750 for yourself and no more than \$15,500 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

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

Covered before you reach the deductible

With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a \$30 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance

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

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd pay a \$50 copay for urgent care visits, whether or not you have met your deductible.

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

- KP** Offered through Kaiser Permanente
- M** Offered through the Health Insurance Marketplace

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on healthcare.gov.

	KP M KP VA Bronze 5500/50/Dental	KP M KP VA Silver 6000/35/Dental	KP M KP VA Silver 3200/20%/HSA/ Dental	KP M KP VA Silver 2500/30/Dental
Plan type	Deductible	Deductible	HSA-qualified	Deductible
Features				
Annual medical deductible (individual/family)	\$5,500/\$11,000	\$6,000/\$12,000	\$3,200/\$6,400	\$2,500/\$5,000
Annual out-of-pocket maximum (individual/family)	\$7,900/\$15,800	\$7,900/\$15,800	\$6,000/\$12,000	\$7,750/\$15,500
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	First 3 visits, \$50 then \$50 after deductible ^{††} (waived for children under 5)	\$35 (waived for children under 5)	20% after deductible	\$30 (waived for children under 5)
Specialty care office visit	\$70 after deductible	\$55	20% after deductible	\$50
Most X-rays	\$110	\$50	20% after deductible	\$50
Most lab tests	\$40	\$35	20% after deductible	\$30
MRI, CT, PET	\$625 after deductible	35% after deductible	20% after deductible	35% after deductible
Outpatient surgery	35% after deductible	35% after deductible	20% after deductible	35% after deductible
Mental health visit	\$50 (individual therapy)	\$35 (individual therapy)	20% after deductible	\$30 (individual therapy)
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	35% after deductible	20% after deductible	35% after deductible
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	35% after deductible	20% after deductible	35% after deductible
Emergency and urgent care				
Emergency Department visit	35% after deductible	35% after deductible	20% after deductible	35% after deductible
Urgent care visit	\$70 after deductible	\$55	20% after deductible	\$50
Prescription drugs (up to a 30-day supply)				
Generic	\$25 [†]	\$20 [†]	\$15 after deductible [†]	\$15 [†]
Preferred brand	\$100 after \$1,000 pharmacy deductible per member [†]	\$60 after \$750 pharmacy deductible per member [†]	\$55 after deductible [†]	\$55 after \$750 pharmacy deductible per member [†]
Non-preferred brand	50% after \$1,000 pharmacy deductible per member	35% after \$750 pharmacy deductible per member	20% after deductible	35% after \$750 pharmacy deductible per member
Specialty	50% after \$1,000 pharmacy deductible per member up to \$250 maximum per 30-day prescription	35% after \$750 pharmacy deductible per member up to \$250 maximum per 30-day prescription	30% after deductible up to \$250 maximum per 30-day prescription	35% after \$750 pharmacy deductible per member up to \$250 maximum per 30-day prescription
Whole health				
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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

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

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

^{††}Includes 3 primary care office visits at \$50 before your deductible applies.

- KP** Offered through Kaiser Permanente
- M** Offered through the Health Insurance Marketplace

Financial assistance options with lower copays, coinsurance, and deductibles are available for certain plans, and for Native Alaskans and American Indians on healthcare.gov.

	KP M KP VA Gold 1500/20/Dental	KP M KP VA Gold 1000/20/Dental	KP M KP VA Gold 0/20/Dental	KP M KP VA Platinum 0/5/Dental	KP M KP VA Catastrophic ^c 7900/0/Dental
Plan type	Deductible	Deductible	Copayment	Copayment	Deductible
Features					
Annual medical deductible (individual/family)	\$1,500/\$3,000	\$1,000/\$2,000	None/None	None/None	\$7,900/\$15,800
Annual out-of-pocket maximum (individual/family)	\$6,850/\$13,700	\$6,850/\$13,700	\$6,850/\$13,700	\$4,000/\$8,000	\$7,900/\$15,800
Benefits					
Preventive care					
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)					
Primary care office visit	\$20 (waived for children under 5)	\$20 (waived for children under 5)	\$20 (waived for children under 5)	\$5 (waived for children under 5)	First 3 office visits no charge.** Additional visits no charge after deductible.
Specialty care office visit	\$40	\$40	\$40	\$15	No charge after deductible
Most X-rays	\$40	\$40	\$40	\$5	No charge after deductible
Most lab tests	\$20	\$20	\$20	\$5	No charge after deductible
MRI, CT, PET	35% after deductible	\$500	\$500	\$150	No charge after deductible
Outpatient surgery	35% after deductible	35% after deductible	35%	\$350	No charge after deductible
Mental health visit	\$20 (individual therapy)	\$20 (individual therapy)	\$20 (individual therapy)	\$5 (individual therapy)	First 3 office visits no charge.** Additional visits no charge after deductible.
Inpatient hospital care					
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	35% after deductible	35%	\$350 per day up to 4 days*	No charge after deductible
Maternity					
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	35% after deductible	35%	\$350 per day up to 4 days*	No charge after deductible
Emergency and urgent care					
Emergency Department visit	35% after deductible	\$500 (waived if admitted)	\$500 (waived if admitted)	\$250 (waived if admitted)	No charge after deductible
Urgent care visit	\$40	\$40	\$40	\$15	No charge after deductible
Prescription drugs (up to a 30-day supply)					
Generic	\$10 ¹	\$10 ¹	\$10 ¹	\$5 ¹	No charge after deductible
Preferred brand	\$30 after \$200 pharmacy deductible per member ¹	\$30 ¹	\$30 ¹	\$30 ¹	No charge after deductible
Non-preferred brand	35% after \$200 pharmacy deductible per member	35%	35%	\$50 ¹	No charge after deductible
Specialty	35% after \$200 pharmacy deductible per member up to \$250 maximum per 30-day prescription	35% up to \$250 maximum per 30-day prescription	35% up to \$250 maximum per 30-day prescription	\$150 ¹	No charge after deductible
Whole health					
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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

¹Mail order: 90-day supply of qualified prescriptions for the cost of a 60-day supply.

¹Only applicants under age 30, or applicants age 30 and older who provide a certificate from the Health Insurance Marketplace in Virginia demonstrating hardship or lack of affordable coverage, may purchase a KP VA Catastrophic 7900/0/Dental plan.

**The KP VA Catastrophic 7900/0/Dental plan includes 3 office visits at no charge before your deductible applies. Office visits include primary care or outpatient mental health office visit.

M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Silver 3500/30/CSR/Dental (6000)	M KP VA Silver 0/15/CSR/Dental (6000)	M KP VA Silver 0/5/CSR/Dental (6000)
Plan type	Deductible	Copayment	Copayment
Features			
Annual medical deductible (individual/family)	\$3,500/\$7,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	\$6,300/\$12,600	\$2,600/\$5,200	\$2,000/\$4,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	\$30 (waived for children under 5)	\$15 (waived for children under 5)	\$5 (waived for children under 5)
Specialty care office visit	\$50	\$30	\$5
Most X-rays	\$50	\$20	\$5
Most lab tests	\$30	\$15	\$5
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	\$30 (individual therapy)	\$15 (individual therapy)	\$5 (individual therapy)
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%
Emergency and urgent care			
Emergency Department visit	35% after deductible	30%	10%
Urgent care visit	\$50	\$30	\$5
Prescription drugs (up to a 30-day supply)			
Generic	\$15 [†]	\$10 [†]	\$5 [†]
Preferred brand	\$55 after \$250 pharmacy deductible per member [†]	\$55 [†]	\$10 [†]
Non-preferred brand	35% after \$250 pharmacy deductible per member	30%	10%
Specialty	35% after \$250 pharmacy deductible per member up to \$250 maximum per 30-day prescription	30% up to \$250 maximum per 30-day prescription	10% up to \$250 maximum per 30-day prescription
Whole health			
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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

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

^{††}Includes 3 primary care office visits at \$50 before your deductible applies.

M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Silver 1700/20%/CSR/HDHP/Dental (3200)	M KP VA Silver 500/10%/CSR/HDHP/Dental (3200)	M KP VA Silver 100/5%/CSR/HDHP/Dental (3200)
Plan type	Deductible	Deductible	Deductible
Features			
Annual medical deductible (individual/family)	\$1,700/\$3,400	\$500/\$1,000	\$100/\$200
Annual out-of-pocket maximum (individual/family)	\$6,000/\$12,000	\$2,250/\$4,500	\$2,250/\$4,500
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	20% after deductible	10% after deductible	5% after deductible
Specialty care office visit	20% after deductible	10% after deductible	5% after deductible
Most X-rays	20% after deductible	10% after deductible	5% after deductible
Most lab tests	20% after deductible	10% after deductible	5% after deductible
MRI, CT, PET	20% after deductible	10% after deductible	5% after deductible
Outpatient surgery	20% after deductible	10% after deductible	5% after deductible
Mental health visit	20% after deductible	10% after deductible	5% after deductible
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	20% after deductible	10% after deductible	5% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	20% after deductible	10% after deductible	5% after deductible
Emergency and urgent care			
Emergency Department visit	20% after deductible	10% after deductible	5% after deductible
Urgent care visit	20% after deductible	10% after deductible	5% after deductible
Prescription drugs (up to a 30-day supply)			
Generic	\$15 after deductible [†]	\$10 after deductible [†]	\$5 after deductible [†]
Preferred brand	\$55 after deductible [†]	\$35 after deductible [†]	\$10 after deductible [†]
Non-preferred brand	20% after deductible	10% after deductible	5% after deductible
Specialty	30% after deductible up to \$250 maximum per 30-day prescription	10% after deductible up to \$250 maximum per 30-day prescription	5% after deductible up to \$250 maximum per 30-day prescription
Whole health			
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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

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

^{††}Includes 3 primary care office visits at \$50 before your deductible applies.

M Offered through the Health Insurance Marketplace

Cost Share Reduction (CSR) Plans

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

	M KP VA Silver 2200/30/CSR/ Dental (2500)	M KP VA Silver 0/10/CSR/ Dental (2500)	M KP VA Silver 0/5/CSR/ Dental (2500)
Plan type	Deductible	Copayment	Copayment
Features			
Annual medical deductible (individual/family)	\$2,200/\$4,400	None/None	None/None
Annual out-of-pocket maximum (individual/family)	\$6,300/\$12,600	\$2,600/\$5,200	\$1,800/\$3,600
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	\$30 (waived for children under 5)	\$10 (waived for children under 5)	\$5 (waived for children under 5)
Specialty care office visit	\$50	\$20	\$5
Most X-rays	\$50	\$30	\$10
Most lab tests	\$30	\$20	\$5
MRI, CT, PET	35% after deductible	30%	10%
Outpatient surgery	35% after deductible	30%	10%
Mental health visit	\$30 (individual therapy)	\$10 (individual therapy)	\$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	35% after deductible	30%	10%
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	35% after deductible	30%	10%
Emergency and urgent care			
Emergency Department visit	35% after deductible	30%	10%
Urgent care visit	\$50	\$20	\$5
Prescription drugs (up to a 30-day supply)			
Generic	\$15 [†]	\$10 [†]	\$5 [†]
Preferred brand	\$55 after \$750 pharmacy deductible per member [†]	\$50 [†]	\$10 [†]
Non-preferred brand	35% after \$750 pharmacy deductible per member	30%	10%
Specialty	35% after \$750 pharmacy deductible per member up to \$250 maximum per 30-day prescription	30% up to \$250 maximum per 30-day prescription	20% up to \$250 maximum per 30-day prescription
Whole health			
Healthy services	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)	Dental preventive services: \$30 for adults; \$0 plus an office visit fee for children under 19 (includes cleaning, oral evaluation, and bitewing X-rays)

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

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

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

^{††}Includes 3 primary care office visits at \$50 before your deductible applies.

Find your rate

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

What determines your rate?

Your rate is based on the following:

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

Interested in a family plan?

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

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

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

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

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

2019 Non-tobacco monthly rates

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

Age on 2019 effective date	KP VA Bronze 5500/50/ Dental	KP VA Silver 6000/35/ Dental	KP VA Silver 3200/20%/ HSA/Dental	KP VA Silver 2500/30/ Dental	KP VA Gold 1500/20/ Dental	KP VA Gold 1000/20/ Dental	KP VA Gold 0/20/Dental	KP VA Platinum 0/5/Dental	KP VA Catastrophic 7900/0/ Dental	KP VA Silver 3500/30/ CSR/Dental (6000)	KP VA Silver 0/15/CSR/ Dental (6000)
0-14	\$309.71	\$382.19	\$403.97	\$430.04	\$365.84	\$374.76	\$385.47	\$445.55	\$224.96	\$382.19	\$382.19
15	337.24	416.16	439.88	468.26	398.35	408.07	419.74	485.15	244.96	416.16	416.16
16	347.77	429.15	453.61	482.88	410.79	420.81	432.84	500.30	252.60	429.15	429.15
17	358.30	442.14	467.34	497.49	423.22	433.54	445.94	515.44	260.25	442.14	442.14
18	369.63	456.12	482.13	513.23	436.61	447.26	460.05	531.75	268.48	456.12	456.12
19	380.97	470.11	496.91	528.97	450.00	460.98	474.16	548.05	276.71	470.11	470.11
20	392.71	484.60	512.23	545.28	463.87	475.18	488.77	564.94	285.24	484.60	484.60
21	404.85	499.59	528.07	562.14	478.22	489.88	503.89	582.42	294.06	499.59	499.59
22	404.85	499.59	528.07	562.14	478.22	489.88	503.89	582.42	294.06	499.59	499.59
23	404.85	499.59	528.07	562.14	478.22	489.88	503.89	582.42	294.06	499.59	499.59
24	404.85	499.59	528.07	562.14	478.22	489.88	503.89	582.42	294.06	499.59	499.59
25	406.47	501.59	530.18	564.39	480.13	491.84	505.90	584.75	295.24	501.59	501.59
26	414.57	511.58	540.74	575.63	489.69	501.64	515.98	596.39	301.12	511.58	511.58
27	424.29	523.57	553.42	589.12	501.17	513.39	528.07	610.37	308.18	523.57	523.57
28	440.08	543.05	574.01	611.05	519.82	532.50	547.72	633.09	319.65	543.05	543.05
29	453.03	559.04	590.91	629.03	535.13	548.17	563.85	651.72	329.06	559.04	559.04
30	459.51	567.03	599.36	638.03	542.78	556.01	571.91	661.04	333.76	567.03	567.03
31	469.23	579.02	612.03	651.52	554.25	567.77	584.00	675.02	340.82	579.02	579.02
32	478.94	591.01	624.71	665.01	565.73	579.53	596.10	689.00	347.88	591.01	591.01
33	485.02	598.51	632.63	673.44	572.90	586.88	603.65	697.73	352.29	598.51	598.51
34	491.49	606.50	641.08	682.44	580.56	594.71	611.72	707.05	356.99	606.50	606.50
35	494.73	610.50	645.30	686.94	584.38	598.63	615.75	711.71	359.35	610.50	610.50
36	497.97	614.49	649.53	691.43	588.21	602.55	619.78	716.37	361.70	614.49	614.49
37	501.21	618.49	653.75	695.93	592.03	606.47	623.81	721.03	364.05	618.49	618.49
38	504.45	622.49	657.97	700.43	595.86	610.39	627.84	725.69	366.40	622.49	622.49
39	510.93	630.48	666.42	709.42	603.51	618.23	635.90	735.01	371.11	630.48	630.48
40	517.40	638.47	674.87	718.42	611.16	626.07	643.97	744.33	375.81	638.47	638.47
41	527.12	650.46	687.55	731.91	622.64	637.82	656.06	758.31	382.87	650.46	650.46
42	536.43	661.95	699.69	744.84	633.64	649.09	667.65	771.70	389.63	661.95	661.95
43	549.39	677.94	716.59	762.82	648.94	664.77	683.77	790.34	399.04	677.94	677.94
44	565.58	697.93	737.71	785.31	668.07	684.36	703.93	813.64	410.81	697.93	697.93
45	584.61	721.41	762.53	811.73	690.55	707.39	727.61	841.01	424.63	721.41	721.41
46	607.28	749.38	792.10	843.21	717.33	734.82	755.83	873.62	441.10	749.38	749.38
47	632.79	780.86	825.37	878.63	747.45	765.68	787.57	910.32	459.62	780.86	780.86
48	661.94	816.83	863.39	919.10	781.89	800.95	823.85	952.25	480.79	816.83	816.83
49	690.68	852.30	900.89	959.01	815.84	835.73	859.63	993.60	501.67	852.30	852.30
50	723.07	892.27	943.13	1,003.98	854.10	874.92	899.94	1,040.20	525.20	892.27	892.27
51	755.05	931.73	984.85	1,048.39	891.88	913.62	939.75	1,086.21	548.43	931.73	931.73
52	790.28	975.20	1,030.79	1,097.30	933.48	956.24	983.58	1,136.88	574.01	975.20	975.20
53	825.90	1,019.16	1,077.26	1,146.77	975.56	999.35	1,027.93	1,188.13	599.89	1,019.16	1,019.16
54	864.36	1,066.62	1,127.43	1,200.17	1,020.99	1,045.89	1,075.79	1,243.46	627.83	1,066.62	1,066.62
55	902.83	1,114.08	1,177.59	1,253.57	1,066.42	1,092.43	1,123.66	1,298.79	655.76	1,114.08	1,114.08
56	944.53	1,165.54	1,231.99	1,311.47	1,115.68	1,142.89	1,175.56	1,358.78	686.05	1,165.54	1,165.54
57	986.63	1,217.50	1,286.90	1,369.94	1,165.42	1,193.84	1,227.97	1,419.35	716.63	1,217.50	1,217.50
58	1,031.57	1,272.95	1,345.52	1,432.33	1,218.50	1,248.21	1,283.90	1,484.00	749.28	1,272.95	1,272.95
59	1,053.84	1,300.43	1,374.56	1,463.25	1,244.80	1,275.16	1,311.61	1,516.03	765.45	1,300.43	1,300.43
60	1,098.78	1,355.88	1,433.18	1,525.65	1,297.88	1,329.53	1,367.54	1,580.68	798.09	1,355.88	1,355.88
61	1,137.64	1,403.84	1,483.87	1,579.61	1,343.79	1,376.56	1,415.92	1,636.59	826.32	1,403.84	1,403.84
62	1,163.15	1,435.32	1,517.14	1,615.03	1,373.92	1,407.42	1,447.66	1,673.28	844.85	1,435.32	1,435.32
63	1,195.13	1,474.79	1,558.86	1,659.44	1,411.70	1,446.12	1,487.47	1,719.29	868.08	1,474.79	1,474.79
64+	1,214.56	1,498.77	1,584.21	1,686.42	1,434.65	1,469.64	1,511.66	1,747.25	882.19	1,498.77	1,498.77

Rates are effective January 1, 2019, through December 31, 2019.

2019 Non-tobacco monthly rates

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

Age on 2019 effective date	KP VA Silver 0/5/CSR/Dental (6000)	KP VA Silver 1700/20%/CSR/HDHP/Dental (3200)	KP VA Silver 500/10%/CSR/HDHP/Dental (3200)	KP VA Silver 100/5%/CSR/HDHP/Dental (3200)	KP VA Silver 2200/30%/CSR/Dental (2500)	KP VA Silver 0/10/CSR/Dental (2500)	KP VA Silver 0/5/CSR/Dental (2500)	KP VA Silver 6000/35/Dental	KP VA Silver 3200/20%/HSA/Dental	KP VA Silver 2500/30/Dental
0-14	\$382.19	\$403.97	\$403.97	\$403.97	\$430.04	\$430.04	\$430.04	\$314.77	\$332.71	\$354.18
15	416.16	439.88	439.88	439.88	468.26	468.26	468.26	342.75	362.29	385.66
16	429.15	453.61	453.61	453.61	482.88	482.88	482.88	353.44	373.59	397.70
17	442.14	467.34	467.34	467.34	497.49	497.49	497.49	364.14	384.90	409.74
18	456.12	482.13	482.13	482.13	513.23	513.23	513.23	375.66	397.08	422.70
19	470.11	496.91	496.91	496.91	528.97	528.97	528.97	387.18	409.26	435.66
20	484.60	512.23	512.23	512.23	545.28	545.28	545.28	399.12	421.87	449.09
21	499.59	528.07	528.07	528.07	562.14	562.14	562.14	411.46	434.92	462.98
22	499.59	528.07	528.07	528.07	562.14	562.14	562.14	411.46	434.92	462.98
23	499.59	528.07	528.07	528.07	562.14	562.14	562.14	411.46	434.92	462.98
24	499.59	528.07	528.07	528.07	562.14	562.14	562.14	411.46	434.92	462.98
25	501.59	530.18	530.18	530.18	564.39	564.39	564.39	413.11	436.66	464.83
26	511.58	540.74	540.74	540.74	575.63	575.63	575.63	421.34	445.36	474.09
27	523.57	553.42	553.42	553.42	589.12	589.12	589.12	431.21	455.79	485.20
28	543.05	574.01	574.01	574.01	611.05	611.05	611.05	447.26	472.76	503.26
29	559.04	590.91	590.91	590.91	629.03	629.03	629.03	460.42	486.67	518.07
30	567.03	599.36	599.36	599.36	638.03	638.03	638.03	467.01	493.63	525.48
31	579.02	612.03	612.03	612.03	651.52	651.52	651.52	476.88	504.07	536.59
32	591.01	624.71	624.71	624.71	665.01	665.01	665.01	486.76	514.51	547.70
33	598.51	632.63	632.63	632.63	673.44	673.44	673.44	492.93	521.03	554.65
34	606.50	641.08	641.08	641.08	682.44	682.44	682.44	499.51	527.99	562.06
35	610.50	645.30	645.30	645.30	686.94	686.94	686.94	502.81	531.47	565.76
36	614.49	649.53	649.53	649.53	691.43	691.43	691.43	506.10	534.95	569.46
37	618.49	653.75	653.75	653.75	695.93	695.93	695.93	509.39	538.43	573.17
38	622.49	657.97	657.97	657.97	700.43	700.43	700.43	512.68	541.91	576.87
39	630.48	666.42	666.42	666.42	709.42	709.42	709.42	519.26	548.87	584.28
40	638.47	674.87	674.87	674.87	718.42	718.42	718.42	525.85	555.82	591.69
41	650.46	687.55	687.55	687.55	731.91	731.91	731.91	535.72	566.26	602.80
42	661.95	699.69	699.69	699.69	744.84	744.84	744.84	545.19	576.27	613.45
43	677.94	716.59	716.59	716.59	762.82	762.82	762.82	558.35	590.18	628.26
44	697.93	737.71	737.71	737.71	785.31	785.31	785.31	574.81	607.58	646.78
45	721.41	762.53	762.53	762.53	811.73	811.73	811.73	594.15	628.02	668.54
46	749.38	792.10	792.10	792.10	843.21	843.21	843.21	617.19	652.38	694.47
47	780.86	825.37	825.37	825.37	878.63	878.63	878.63	643.11	679.78	723.63
48	816.83	863.39	863.39	863.39	919.10	919.10	919.10	672.74	711.09	756.97
49	852.30	900.89	900.89	900.89	959.01	959.01	959.01	701.95	741.97	789.84
50	892.27	943.13	943.13	943.13	1,003.98	1,003.98	1,003.98	734.87	776.76	826.88
51	931.73	984.85	984.85	984.85	1,048.39	1,048.39	1,048.39	767.37	811.12	863.45
52	975.20	1,030.79	1,030.79	1,030.79	1,097.30	1,097.30	1,097.30	803.17	848.96	903.73
53	1,019.16	1,077.26	1,077.26	1,077.26	1,146.77	1,146.77	1,146.77	839.38	887.23	944.48
54	1,066.62	1,127.43	1,127.43	1,127.43	1,200.17	1,200.17	1,200.17	878.47	928.55	988.46
55	1,114.08	1,177.59	1,177.59	1,177.59	1,253.57	1,253.57	1,253.57	917.56	969.87	1,032.44
56	1,165.54	1,231.99	1,231.99	1,231.99	1,311.47	1,311.47	1,311.47	959.94	1,014.66	1,080.13
57	1,217.50	1,286.90	1,286.90	1,286.90	1,369.94	1,369.94	1,369.94	1,002.73	1,059.89	1,128.28
58	1,272.95	1,345.52	1,345.52	1,345.52	1,432.33	1,432.33	1,432.33	1,048.40	1,108.17	1,179.67
59	1,300.43	1,374.56	1,374.56	1,374.56	1,463.25	1,463.25	1,463.25	1,071.03	1,132.09	1,205.13
60	1,355.88	1,433.18	1,433.18	1,433.18	1,525.65	1,525.65	1,525.65	1,116.70	1,180.37	1,256.52
61	1,403.84	1,483.87	1,483.87	1,483.87	1,579.61	1,579.61	1,579.61	1,156.20	1,222.12	1,300.97
62	1,435.32	1,517.14	1,517.14	1,517.14	1,615.03	1,615.03	1,615.03	1,182.13	1,249.52	1,330.14
63	1,474.79	1,558.86	1,558.86	1,558.86	1,659.44	1,659.44	1,659.44	1,214.63	1,283.88	1,366.71
64+	1,498.77	1,584.21	1,584.21	1,584.21	1,686.42	1,686.42	1,686.42	1,234.38	1,304.75	1,388.93

Rates are effective January 1, 2019, through December 31, 2019.

Learn about dental and vision coverage

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

A reason to smile

In the Preventive Dental Plan, adults pay a \$30 copay for preventive care procedures such as routine cleanings, oral examinations, and topical fluoride, plus bitewing X-rays.

More extensive care is provided at savings of up to 70 percent or less compared with the usual and customary charges for these services. You pay only the amount listed on the Dominion fee schedule. The combination of predictable costs, no deductibles, and no annual maximums helps you plan for out-of-pocket fees.

Choosing a dentist

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

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

Quality dental care

With the Preventive Dental Plan, you can be confident that your dentist was carefully selected. All dentists go through a quality assurance program developed in accordance with the National Committee for Quality Assurance (NCQA). This process confirms that each dentist has the required credentials and has passed a thorough on-site office

evaluation.

Enhanced adult dental benefits

For an additional premium of \$12.93 per month, adults 19 and older can choose to enroll in an enhanced dental plan that offers orthodontic coverage, a \$10 copay for most preventive care procedures, and even lower fees on more extensive care than the Preventive Dental Plan. To enroll, select the option on your application to enhance your dental coverage with the dental HMO rider.

Essential vision care

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

For information about vision coverage and limitations:

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

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

Register at kp.org and read a summary of your benefits online through My Health Manager.

Find a facility near you

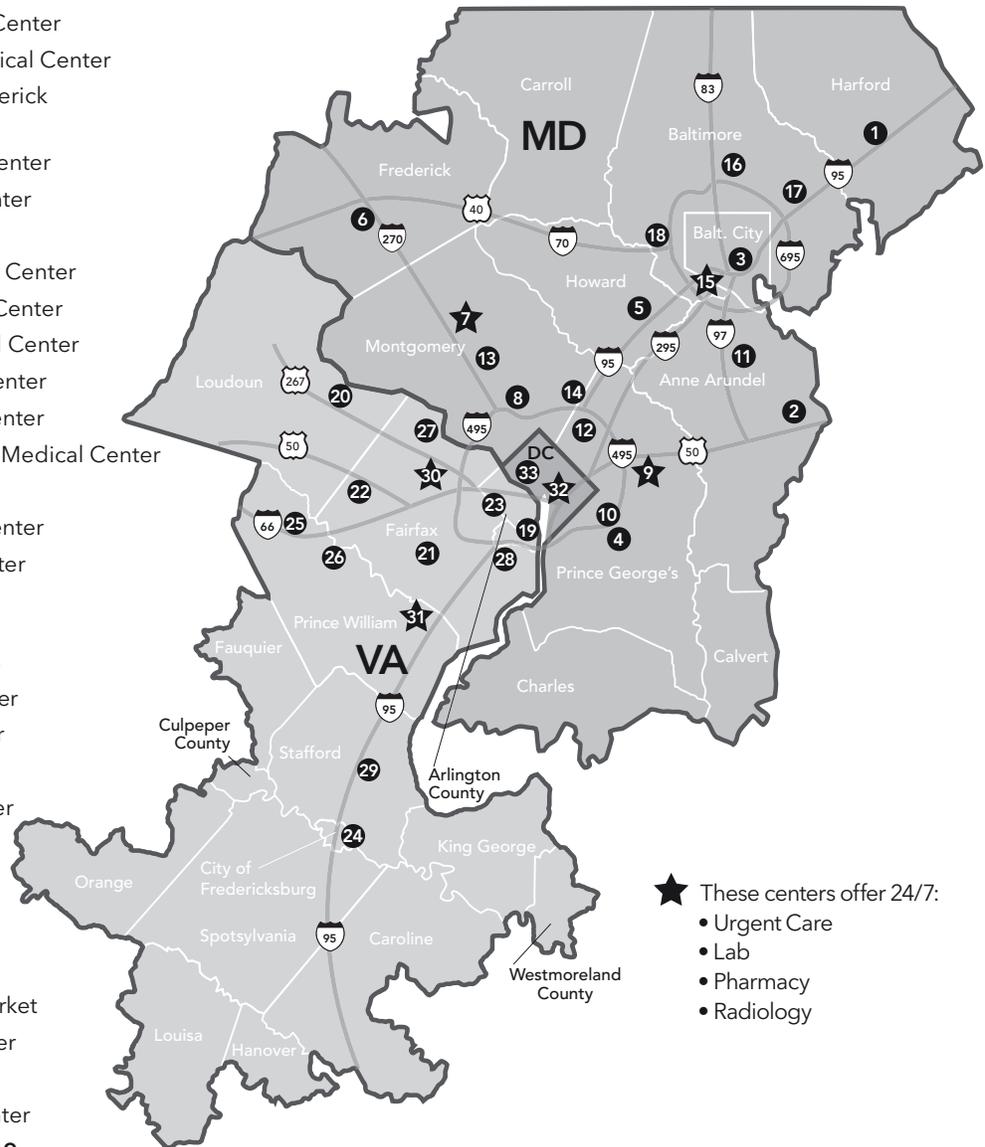
Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or visit kp.org/facilities to find the one nearest you.

Maryland

- 1 Abingdon Medical Center
- 2 Annapolis Medical Center
- 3 Kaiser Permanente Baltimore Harbor Medical Center
- 4 Camp Springs Medical Center
- 5 Columbia Gateway Medical Center
- 6 Kaiser Permanente Frederick Medical Center
- 7 Gaithersburg Medical Center
- 8 Kensington Medical Center
- 9 Largo Medical Center
- 10 Marlow Heights Medical Center
- 11 North Arundel Medical Center
- 12 Prince George's Medical Center
- 13 Shady Grove Medical Center
- 14 Silver Spring Medical Center
- 15 South Baltimore County Medical Center
- 16 Towson Medical Center
- 17 White Marsh Medical Center
- 18 Woodlawn Medical Center

Washington, D.C.

- 32 Kaiser Permanente Capitol Hill Medical Center
- 33 Northwest D.C. Medical Office Building



Virginia

- 19 **OPENING SPRING 2019**
Alexandria Medical Center
- 20 Ashburn Medical Center
- 21 Burke Medical Center
- 22 Fair Oaks Medical Center
- 23 Falls Church Medical Center
- 24 Fredericksburg Medical Center
- 25 **OPENING LATE 2019**
Medical center in Haymarket
- 26 Manassas Medical Center
- 27 Reston Medical Center
- 28 Springfield Medical Center
- 29 **OPENING SUMMER 2019**
Medical center in Stafford
- 30 Tysons Corner Medical Center
- 31 Woodbridge Medical Center

★ These centers offer 24/7:
 • Urgent Care
 • Lab
 • Pharmacy
 • Radiology

Please check kp.org/facilities for the most up-to-date listing of the services located at Kaiser Permanente medical centers.

Have questions? Call us at 1-800-494-5314. • Go to buykp.org/apply. • Or contact your agent or broker.

Important details and notices

Notice of insurance information practices – Abbreviated version

Virginia

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

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

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

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

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

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

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

Exclusions, limitations and coordination of benefits

This section provides you with information on what Services Health Plan will not pay for regardless of whether or not the Service is Medically Necessary. It also provides information on how your benefits may be reduced as the result of other types of coverage.

Your Benefits

The benefits described in this section are covered only when:

1. A Plan Physician determines that the Services are Medically Necessary;
2. The Services are provided, prescribed, authorized or directed by a Plan Physician; and
 - a. You receive the Services at a Plan Facility, Plan Provider or contracted Skilled Nursing Facility inside our Service Area (except when specifically noted otherwise within this Agreement); or
 - b. You agree to have Services delivered through a patient centered medical homes program for individuals with chronic conditions, serious illnesses or complex health care needs. This includes associated costs for coordination of care, such as:
 - i. Liaison services between the individual and the Health Care Provider, nurse coordinator and the care coordination team;
 - ii. Creation and supervision of a care plan;
 - iii. Education of the Member and their family regarding the Member's disease, treatment compliance and self-care techniques; and
 - iv. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

You must receive all covered Services from Plan Providers inside our Service Area except for:

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in *Section 2: How to Get the Care You Need*;
4. Approved referrals, as described under *Getting a Referral* in *Section 2: How to Get the Care You Need*, including referrals for clinical trials as described in this section.

Note: Some benefits may require payment of a Copayment, Coinsurance or Deductible. Refer to the Summary of Services and Cost Shares Appendix for the Cost Sharing requirements that apply to the covered Services contained within the *List of Benefits* in this section.

This Agreement does not pay for all health care services, even if they are Medically Necessary. Your right to benefits is limited to the covered Services contained within this contract. To view your benefits, see the *List of Benefits* in this section.

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under *Exclusions* in this section.

Accidental Dental Injury Services

Benefit-Specific Exclusions:

1. Services provided by non-Plan Providers except in an emergency;
2. Treatment of natural teeth due to diseases;
3. Treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 12 months after the injury;
4. Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.

Refer to the Adult Dental Plan and Pediatric Dental Plan sections for additional dental coverage.

Ambulance Services

Benefit-Specific Exclusions:

1. Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
2. Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

Anesthesia for Dental Services

Benefit-Specific Exclusion:

1. The dentist's or specialist's professional Services.

Clinical Trials

Benefit-Specific Exclusions:

1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Diabetic Services

Benefit-Specific Limitations:

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply was prescribed by a Plan Provider and there is no equivalent preferred equipment or supply available, or an equivalent preferred equipment or supply has been ineffective in treating the disease or condition of the Member, or has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

Drugs, Supplies and Supplements

Benefit-Specific Exclusions:

1. Drugs for which a prescription is not required by law.
2. Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
3. Drugs for the treatment of sexual dysfunction disorders.

Durable Medical Equipment

Benefit-Specific Exclusions:

1. Comfort, convenience, or luxury equipment or features
2. Exercise or hygiene equipment
3. Non-medical items such as sauna baths or elevators
4. Modifications to your home or car
5. Electronic monitors of the heart or lungs, except infant apnea monitors
6. Prosthetic and orthotic devices, except as covered under "Prosthetic Devices"

Emergency Services

Benefit-Specific Limitations:

1. Notification

If you receive care at a hospital emergency room and/or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, not later than 48 hours of any emergency room visit or admission or on the first working day following the emergency room visit or admission, whichever is later, unless it was not reasonably possible to notify us. If admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been stabilized, all continuing and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.

2. Continuing or Follow-Up Treatment

We do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the non-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

3. Hospital Observation

Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit Copayment, if applicable, will not be waived.

Hearing Services

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy.

Home Health Services

Benefit-Specific Limitations:

1. Private-duty nursing is limited to 16 hours per Calendar Year.

Benefit-Specific Exclusions:

1. Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Coordination of Benefits" section).
2. Routine administration of oral medications, eye drops, ointments.
3. General maintenance care of colostomy, ileostomy, and ureterostomy.
4. Medical supplies or dressings applied by a Member or family caregiver.
5. Corrective appliances, artificial aids, and orthopedic devices.
6. Homemaker Services.
7. Services that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
8. Transportation and delivery service costs of Durable Medical Equipment, medications and drugs, medical supplies, and supplements to the home.

Infertility Diagnostic Services

Benefit-Specific Exclusions:

1. Artificial insemination, in vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure.
2. Infertility drugs used in assisted reproductive technology (ART) procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
3. Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
4. Services to reverse voluntary, surgically induced infertility; or fallopian scar revision surgery.

Mental Health Services and Substance Use Disorder

Benefit-Specific Exclusions:

1. Services for Members who, in the opinion of the Plan Provider, are seeking services and supplies for non-therapeutic purposes
2. Applied Behavior Analysis (ABA)
3. Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
4. Evaluations that are primarily for legal or administrative purposes and are not Medically Necessary.

Oral Surgery Services

Benefit-Specific Exclusions:

1. Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures
2. Orthodontic care, except as required in the treatment of cleft lip, cleft palate, or ectodermal dysplasia

Preventive Health Care Services

Benefit-Specific Limitations:

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. The applicable Copayment or Coinsurance will apply:

1. Monitoring a chronic disease;
2. Follow-up Services after you have been diagnosed with a disease;
3. Diagnosis of a specific disease when you show signs or have higher than average risk for the disease;
4. Services when you show signs or symptoms of a specific disease or disease process;
5. Non-routine gynecological visits will be charged at the specialty Copayment;
6. Lab, imaging, and other ancillary Services not included in routine prenatal care.
7. Over-the-counter contraceptive pills, supplies, and devices.
8. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
9. Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
10. Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

Prosthetic Devices

Benefit Specific Limitations:

1. Coverage for mastectomy bras is limited to a maximum of two (2) per Calendar Year.

Benefit Specific Exclusions:

1. Internally implanted breast prostheses for cosmetic purposes.
2. External Prostheses, except as provided in this Section.
3. Repair or replacement of prosthetic devices due to loss, neglect, misuse, or abuse.

4. Hair prosthesis, except as specified above.
5. Artificial limbs designed primarily for an athletic purpose.
6. Microprocessor and robotic controlled external prosthetics and orthotics not covered under the Medicare Coverage Database.
7. Multifocal intraocular lens implants.

Reconstructive Surgery

Benefit-Specific Exclusions:

Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or will not result in significant improvement in physical function. Examples of excluded cosmetic dermatology services are:

1. Removal of moles or other benign skin growths for appearance only
2. Chemical peels
3. Pierced earlobe repairs, except for the repair of an acute bleeding laceration

Routine Foot Care

Benefit-Specific Limitation:

Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Benefit-Specific Exclusions:

Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

Skilled Nursing Facility Care

Benefit Specific Limitations:

We cover up to 100 days of skilled nursing inpatient Services per stay.

Benefit Specific Exclusions:

1. Custodial care (see description in the "Exclusions, Limitations, and Coordination of Benefits" Section).
2. Domiciliary care.
3. See "Therapy; Habilitative and Rehabilitative Services" for coverage of therapy during an inpatient stay.

Telemedicine Services

Benefit-Specific Exclusions:

Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Therapy; Habilitative and Rehabilitative Services

Benefit-Specific Limitations:

1. The limitations listed for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

Benefit-Specific Exclusions:

1. Long-term rehabilitation therapy except as provided for cardiac rehabilitation Services.
2. Cardiac Rehabilitation Services will not be provided for home programs (other than home health care Services), ongoing conditioning and maintenance care.

Transplant Services

Benefit-Specific Exclusions:

Services related to non-human or artificial organs and their implantation.

Urgent Care Services

Benefit-Specific Limitations:

We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Benefit-Specific Exclusions:

Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

Vision Services

Benefit-Specific Exclusions:

1. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
2. Eye exercises;
3. Orthoptic (eye training) therapy;
4. Sunglasses without corrective lenses unless Medically Necessary;
5. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;
6. Non-corrective contact lenses; and
7. Replacement of lost or broken lenses or frames.

Exclusions

This provision provides information on what Services the Health Plan will not pay for regardless of whether or not the Service is Medically Necessary.

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section. When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service. The following services are excluded from coverage:

1. Alternative Medical Services

- a. Acupuncture
- b. Holistic medicine
- c. Homeopathic medicine
- d. Hypnosis
- e. Aroma therapy
- f. Massage and massage therapy
- g. Reiki therapy
- h. Herbal, vitamin or dietary products or therapies
- i. Naturopathy
- j. Thermography
- k. Orthomolecular therapy

- l. Contact reflex analysis
 - m. Bioenergetic synchronization technique (BEST)
 - n. Iridology-study of the iris
 - o. Auditory integration therapy (AIT)
 - p. Colonic irrigation
 - q. Magnetic innervation therapy
 - r. Electromagnetic therapy
 - s. Neurofeedback/Biofeedback.
- 2. Certain Exams and Services**
Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance, licensing, or disability determination, or (c) on court-order or required for parole or probation.
- 3. Cosmetic Services**
Cosmetic Services, including surgery or related Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.
- 4. Court Ordered Testing**
Court ordered testing or care unless Medically Necessary.
- 5. Custodial Care**
Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to custodial care received while under hospice care.
- 6. Dental Care**
Dental care and dental x-rays, including dental appliances, dental implants, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome. This exclusion does not apply to Medically Necessary dental care covered under "Accidental Dental Injury Services", "Cleft-Lip, Cleft-Palate or Ectodermal Dysplasia", or "Oral Surgery" in Section 3, or under "Dental Plans."
- 7. Disposable Supplies**
Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices, not specifically listed as covered in Section 3.
- 8. Durable Medical Equipment**
Except as covered under "Durable Medical Equipment" in Section 3, the following items and Services are excluded:
- a. Comfort, convenience, or luxury equipment or features;
 - b. Exercise or hygiene equipment;
 - c. Non-medical items such as sauna baths or elevators;
 - d. Hydrotherapy equipment;
 - e. Modifications to your home or car; and
 - f. Electronic monitors of the heart or lungs, except infant apnea monitors.
- 9. Employer or Government Responsibility**
Financial responsibility for Services that an employer or government agency is required by law to provide.
- 10. Experimental or Investigational Services**
Except as covered under "Clinical Trials" in Section 3, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:
- a. It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
 - b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
 - c. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

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

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

- a. your medical records,
- b. the written protocols or other documents pursuant to which the Service has been or will be provided,
- c. any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- d. the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- e. the published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury, and
- f. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

11. Family Members

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

12. Health Club Memberships and Fitness Services

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

13. Prosthetic and Orthotic Devices

Prosthetics for sports or cosmetic purposes. Services and supplies for external prosthetic and orthotic devices, except as specifically covered under Section 3 of this Agreement.

14. Routine Foot Care Services

Except for patients with diabetes or vascular disease as specifically covered under Section 3, the following foot care Services (palliative or cosmetic) are excluded:

- a. Flat foot conditions;
- b. Support devices and arch supports;
- c. Foot inserts;
- d. Orthopedic and corrective shoes not part of a leg brace and fitting;
- e. Castings and other services related to devices of the feet;
- f. Foot orthotics;
- g. Subluxations of the foot;
- h. Corns, calluses and care of toenails;
- i. Bunions except for capsular or bone surgery;
- j. Fallen arches;
- k. Weak feet; and
- l. Chronic foot strain or symptomatic complaints of the feet.

15. Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations:

- a. If a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in Section 2: How to Get the Care You Need, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines; or
- b. If travel and lodging expenses are incurred as part of transplant services as described under "Transplant Services" in Section 3: Benefits, Exclusions and Limitations.

16. Vein Treatment

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

17. Workers' Compensation or Employer's Liability

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

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

Limitations

We will make our best efforts to provide or arrange for your health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Office; and/or
7. Complete or partial destruction of facilities.

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

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under *Getting a Second Opinion in Section 2: How to Get the Care You Need*.

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 ሊያገዝዎት 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**).

Bàsóò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsóò-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò b́éin m̀ gbo kpáa. Đá **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.

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 નિ:શુલ્ક 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) NRUBAMA: O bụrụ na i na asụ Igbo, orụ 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 yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, koji' 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: ถ้าวัดคุณพูดภาษาไทย 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 **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).

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