

What this Plan Covers & What You Pay for Covered Services



For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

_____ Yes, but you may self-refer to certain [specialists](#).

This [plan](#) will pay some or all of the costs to see a [specialist](#) for covered services but only if you have a [referral](#) before you see the [specialist](#).

	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None			
	Physician/surgeon fees	No Charge	Not Covered	None			
	<u>Emergency room care</u>	No Charge	No Charge	None			
	<u>Emergency medical transportation</u>	No Charge	No Charge	None			
	<u>Urgent care</u>	No Charge	Not Covered	<u>Non-Plan providers</u> covered when temporarily outside the service area: No Charge			
	Facility fee (e.g., hospital room)	No Charge	Not Covered	None			
	Physician/surgeon fee	No Charge	Not Covered	None			
	Outpatient services	No Charge	Not Covered	No Charge.			
	Inpatient services	No Charge	Not Covered	None			
	Office visits	No Charge, <u>deductible</u> does not apply.	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).			
	Childbirth/delivery professional services	No Charge	Not Covered	None			
	Childbirth/delivery facility	No Charge	Not Covered	None			

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.

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.ccio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the _____ or _____ or _____ al Market pAliciesk Medicarek Medicaidj CHdM, Txd†Axe, and er¿ain @ther Coverage. if you are Alilwible for Ser¿ain



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.

(9 months of in-network pre-natal care and a hospital delivery)

- _____
- _____
- _____
- _____

[Specialist](#) office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (ultrasounds and blood work)
[Specialist](#) visit (anesthesia)

Deductibles	\$3,300 \$3,300
Cost Sharing	

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente¹ follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

No-cost aids and services to people with disabilities to help them communicate better with us, such as:

Qualified sign language interpreters

Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)

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 our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

Medi-Cal: **1-855-839-7613** (TTY 711)

All others: **1-800-464-4000**

In person:

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