KAISER PERMANENTE®: KP HI Standard Bronze 7500/50

Coverage for: Individual/Family | Plan Type: HMO

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 1-800-966-5955 (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 1-800-966-5955 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$7,500 Individual / $15,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,200 Individual / $18,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care services this plan doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-966-5955 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 / visit, deductible does not apply	Not covered	No charge for children through age 18.
	Specialist visit	$100 / visit, deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRI's)	50% coinsurance (specialty, outpatient)	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	Retail: $25 per prescription, deductible does not apply; Mail Order: $50 per prescription, deductible does not apply	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge, deductible does not apply for contraceptives. Subject to formulary guidelines.
	Preferred brand drugs	Retail: $50 per prescription; Mail Order: $100 per prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred brand drugs	Retail: $100 per prescription; Mail Order: $200 per prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	Retail: $500 per prescription; Mail Order: Not covered	Not covered	Up to a 30-day supply (retail); Subject to formulary guidelines, when approved through the exception process.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	None
	Physician/surgeon fees	50% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	Must notify KP within 48 hours if admitted to a non-plan provider; limited to initial emergency only. Copayment/Coinsurance waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance, deductible does not apply	20% coinsurance, deductible does not apply	None
	Urgent care	$75 / visit, deductible does not apply	$75 / visit, deductible does not apply	Non-plan providers are not covered inside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	None
	Physician/surgeon fee	50% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 / visit, deductible does not apply	Not covered	No charge for children through age 18.
	Inpatient services	50% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	50% coinsurance	Not covered	None
	Childbirth/delivery facility services	None	Not covered	Newborn inpatient charges may apply to non-routine care

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Physician visit covered at primary care visit cost share.
	Rehabilitation services	Inpatient: 50% coinsurance; Outpatient: $50 / visit, deductible does not apply	Not covered	None
	Habilitation services	Inpatient: 50% coinsurance; Outpatient: $50 / visit, deductible does not apply	Not covered	None
	Skilled nursing care	50% coinsurance	Not covered	120-day limit/year.
	Durable medical equipment	20% coinsurance, deductible does not apply	Not covered	Diabetic supplies: 50% coinsurance for state mandated diabetes equipment.
	Hospice service	No charge, deductible does not apply	Not covered	Includes two 90-day periods, followed by unlimited number of 60-day periods.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Limited to 1 exam / year, additional visits at office visit cost.
	Children's glasses	No charge, deductible does not apply	Not covered	Hardware limited to 1 frame and lenses (selected styles), or 1 set of contacts per contract period.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult and child)
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Abortion
- Bariatric Surgery
- Hearing Aids (1 aid / ear / 36 months)
- Infertility Treatment
- 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 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 agency in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-966-5955 (TTY: 711) or www.kp.org/memberservices
Hawaii Department of Insurance	1-808-586-2790 or http://cca.hawaii.gov/ins/

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? Not Applicable.

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 1-800-966-5955 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-966-5955 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-966-5955 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-966-5955 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-966-5955 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-966-5955 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-966-5955 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-966-5955 (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 plan's overall deductible** **$7,500**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **50%**
- **Other (blood work) coinsurance** **50%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,500
Copayments	$20
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,020**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$7,500**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **50%**
- **Other (blood work) coinsurance** **50%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$7,500**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **50%**
- **Other (x-ray) coinsurance** **50%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, 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 free 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 free 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 **1-800-966-5955** (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:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

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 **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-966-5955** (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 **1-800-966-5955**（TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-966-5955** (TTY: **711**).

‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-800-966-5955** (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。**1-800-966-5955**（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. **1-800-966-5955** (TTY: **711**)번으로 전화해 주십시오.

ลาว (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōļ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōļ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeļọk wōṇāān. Kaalọk **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti’go Diné Bizaad, saad bee áká’ánída’áwo’dę́ę́’, t’áá jiik’eh, éí ná hóló, kojį’ hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (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 **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA’I: Kapau ‘oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai **1-800-966-5955** (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 **1-800-966-5955** (TTY: **711**).