KAISER PERMANENTE®: KP HI Silver 4000 Ded/600 Rx Ded Al/LTD

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call 1-800-966-5955 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not Applicable.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the <u>out-of-pocket limit?</u>	Premiums, Copayments (not applicable), and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org or call 1-800-966-5955 (TTY: 711) for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, but you may self-refer to certain specialists.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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	Primary care visit to treat an injury or illness	No charge	Not covered	None	
care provider's	Specialist visit	No charge	Not covered	None	
office or clinic	Preventive care/ screening/ immunization	No charge	Not covered	None	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Inpatient included in hospital facility fee	
ii you ilave a test	Imaging (CT/PET scans, MRI's)	No charge	Not covered	Inpatient included in hospital facility fee	
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	No charge	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	No charge (retail); No charge (mail order)	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	No charge (retail); No charge (mail order)	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	No charge (retail); Not covered (mail order)	Not covered	Up to a 30-day supply (retail); Subject to formulary guidelines, when approved through the exception process.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None	
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None	

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

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Home health care	No charge	Not covered	None	
	Rehabilitation services	No charge	Not covered	None	
If you need help	Habilitation services	No charge	Not covered	None	
recovering or have other special health	Skilled nursing care	No charge	Not covered	120-day limit/year.	
needs	Durable medical equipment	No charge	Not covered	None	
	Hospice service	No charge	Not covered	Coverage is limited to two 90-day periods, followed by an unlimited number of 60-day periods	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per calendar year	
	Children's glasses	No charge	Not covered	Limited to one pair of lenses (polycarbonate single vision, lined bifocal or lined trifocal) and one frame (from the "value collection frames") per calendar year	
	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)
- 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 with limits
- Bariatric Surgery with limits

- Hearing Aids with limits
- Infertility Treatment with limits

• Routine Eye Care with limits (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 <u>www.kp.org/memberservices</u>
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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ Specialist copayment \$ ■ Hospital (facility) copayment \$	0 ■ The <u>plan's</u> overall <u>deductible</u> 0 ■ <u>Specialist copayment</u> 0 ■ Hospital (facility) <u>copayment</u> 0 ■ Other (blood work) <u>copayment</u>	\$0 \$0	 ■ The plan's overall deductible ■ Specialist copayment ■ Hospital (facility) copayment ■ Other (x-ray) copayment \$0 	
This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)	This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	

Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$50	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$50	The total Joe would pay is	\$0	The total Mia would pay is	\$0

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, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille, and accessible electronic formats
- Provides 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.isf, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) PAGPAHIMANGNO: Kung nag-istorya ka og Cebuano, ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (Chinese) 注意事項: 如果您說中文,您可獲得免費語言協助服務,包括適當的輔助器材和服務。致電 1-800-966-5955(TTY:711)。

Chuuk (Chukese) ESINESIN: Ika en mi sine Fosun Chuuk, mi kawor aninisin fosun fonu mei pachonong pisekin aninis, ese kamo, mi kawor ngonuk. Kekeri 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 nā lawelawe kōkua 'ōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi 'ole, loa'a i ke kōkua manuahi. E kelepona i ka helu 1-800-966-5955 (TTY: 711).

Iloko (Ilocano) ATENSION: No makasaoka iti Ilokano, dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-966-5955** (TTY: **711**)

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-800-966-5955 までお電話ください (TTY: 711)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. 1-800-966-5955 (TTY: 711) 로 전화해 주세요.

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-966-5955 (TTY: 711).

Kajin Majōļ (Marshallese) Roñjake: Ñe kwōjeļā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jerbal ko jet, ejjeļok oṇāāer, repeļļok ñan eok. Kūr tok **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-966-5955 (TTY: 711).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien me kele mehlel oh sarawi kan me pahn limpoak, en kak sawa ni ke, lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) FA'AMALU: Afai e te tautala i le Gagana Samoa, o auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totogi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA: Kapau 'oku ke lea Faka-Tonga, 'oku 'i ai ha sevesi tokoni fakatonu lea pea mo ha naunau me'a fanongo, 'oku ta'etotongi, mo faingamalie kiate koe. Taa 1-800-966-5955 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-966-5955** (TTY: **711**).

