**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 www.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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not Applicable. | 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?** | Medical: $2,500 Individual / $5,000 Family<br>Drug: $6,100 Individual / $12,200 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, health care this plan doesn't cover, and services 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 Plan 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 | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 / visit | Not covered | No charge for children through age 17. |
| | Specialist visit | $20 / visit | Not covered | None |
| | Preventive care/screening/ immunization | No charge | 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) | Lab: $20 / day (basic)<br>X-ray: $20 / day | Not covered | Lab: 20% coinsurance (specialty) |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.kp.org/formulary | Generic drugs | $20 (retail); $40 (mail order) / prescription | Not covered | $5 for Generic maintenance medications (retail). Up to a 30-day supply (retail) or 100-day supply (mail order). No charge for contraceptives. Subject to formulary guidelines. |
| | Preferred brand drugs | $75 (retail); $150 (mail order) / prescription | Not covered | Up to a 30-day supply (retail) or 100-day supply (mail order). Subject to formulary guidelines. |
| | Non-preferred brand drugs | $75 (retail); $150 (mail order) / prescription | Not covered | Up to a 30-day supply (retail) or 100-day supply (mail order). Subject to formulary guidelines, when approved through the exception process. |
| | Specialty drugs | $200 (retail) / prescription | 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) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | Must notify KP within 48 hours if admitted to a Non-plan provider; limited to initial emergency only. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $20 / visit | 20% coinsurance (out of area) | Non-plan providers are not covered inside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 / visit | Not covered | No charge for children through age 17. |
| | Inpatient services | 20% coinsurance | 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 |
| **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 copay. |
| | Rehabilitation services | $20 / visit (outpatient);<br>20% coinsurance (inpatient). | Not covered | None |
| | Habilitation services | $20 / visit | Not covered | None |
| | Skilled nursing care | 20% coinsurance | Not covered | Limited to 120 days / benefit period |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| | Durable medical equipment | 10% coinsurance;<br>50% coinsurance<br>Diabetic supplies and equipment. | Not covered | Subject to formulary guidelines. |
| | Hospice services | No charge | 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 for refractive exam | Not covered | Limited to 1 exam / year |
| | Children's glasses | No charge | Not covered | Limited to one pair of frames and lenses or contact lenses / 12 months |
| | 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 travelling 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.)**

- Bariatric surgery
- Hearing aids (1 aid / ear / 36 months)
- Infertility treatment (1 in vitro procedure limit / lifetime)
- 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 agencies 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 |
| 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.cciio.cms.gov |
| 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? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-966-5955 (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, ȧ'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 | $0 |
| Specialist copayment | $20 |
| Hospital (facility) copayment | $0 |
| Other (blood work) copayment | $20 |

**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 | $0 |
| Copayments | $20 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$70** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| Other (blood work) copayment | $20 |

**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 | $600 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,000** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| Other (x-ray) copayment | $20 |

**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 | $0 |
| Copayments | $200 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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.jsf, or by mail or phone at:

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

This notice is available at https://healthy.kaiserpermanente.org/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**).

**ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI:** Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke nā lawelawe kōkua ʻōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi ʻole, loaʻa 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 Majōḷ (Marshallese) Roñjake:** Ñe kwōjeḷā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jerbal ko jet, ejjeḷọk oṇāāer, repeḷḷok 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’dęę́’, biniit’aa da beeso ndinish’aah t’aala’I bi’aa ‘anashwo’ doo biniit’aa, t’aadoo baahilinigoo bits’aadoo yeel, t’áá jiik’eh, éí ná hóló, koji̯’ 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**).