**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 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands . 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 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands 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?** | $1,500 Individual/ $4,500 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 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands 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 providers 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 | $10/visit | Not Covered | None |
| | Specialist visit | $10/visit | Not Covered | None |
| | Preventive care/ screening/ immunization | No charge for immunizations; 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) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRI's) | No Charge | Not Covered | Inpatient fee included in hospital stay |
| **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 | $10 retail; $20 mail order/ prescription | Not Covered | Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Preferred brand drugs | $10 retail; $20 mail order/ prescription | Not Covered | Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Non-preferred brand drugs | $10 retail; $20 mail order/ prescription | Not Covered | Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Specialty drugs | $10 retail prescription | Not Covered | Up to 30-day retail. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |

| 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) | $10/visit | Not Covered | None |
| | Physician/surgeon fees | Included in the facility fee | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $25/visit | Covered under HMO benefit | Must notify KP within 48 hours if admitted to a non plan provider; Limited to initial emergency only |
| | Emergency medical transportation | 20% coinsurance | Covered under HMO benefit | None |
| | Urgent care | $10/visit; $10 IN-AREA / 20% coinsurance (out of area) | Covered under HMO benefit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not Covered | None |
| | Physician/surgeon fee | Included in the facility fee | Not Covered | None |
| **If you need mental health, or substance abuse services** | Outpatient services | **Kaiser:** $10/visit<br>**ARP:** No charge | **Kaiser:** Not Covered<br>**ARP:** No charge | **Kaiser:** None<br>**ARP:** Additional substance abuse benefits available through Assistance Recovery Program (ARP). |
| | Inpatient services | **Kaiser:** No Charge<br>**ARP:** No charge | **Kaiser:** Not Covered<br>**ARP:** No charge | **Kaiser:** None<br>**Additional substance abuse benefits are available through Assistance Recovery Program (ARP).** Preauthorization by ARP is required if you are not Medicare eligible. |

| 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 are pregnant** | Office visits | No Charge/Confirmed pregnancy | 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 | Delivery: No Charge. | Not Covered | No Charge, newborn inpatient |
| | Childbirth/delivery facility services | Delivery: No Charge. | Not Covered | No Charge, newborn inpatient |
| **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 | No Charge (inpatient); $10/visit (outpatient) | Not Covered | None |
| | Habilitation services | Not covered | Not Covered | No coverage for habilitation |
| | Skilled nursing care | No Charge | Not Covered | Limited to 120 days/benefit period |
| | Durable medical equipment | 50% coinsurance diabetes equipment | Not Covered | 20% for all other equipment |
| | Hospice service | 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 | $10/visit | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | No coverage for Dental Check-up |

**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<br>● Children's dental check-up | ● Cosmetic Surgery<br>● Dental care (Adult and Child) covered under a separate dental plan. | ● Non-Emergency Care when Travelling Outside the U.S. |
| ● Children's glasses<br>● Chiropractic Care | ● Habilitation services<br>● Long-Term/Custodial Nursing Home Care | ● Private-Duty Nursing<br>● Routine Foot Care<br>● 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<br>● Hearing Aids (Every 3 years) | ● Infertility Treatment | ● Routine eye care (Adult) additional coverage available under a separate vision plan. |

**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 | 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands 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 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

*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** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) 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*)

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

## 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** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

**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 | $400 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$700** |

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (x-ray) copayment** **$0**

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

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

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