

 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 <https://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 <u>deductible</u> ?	\$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 <u>deductible</u> ?	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 cost sharing 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,500 Individual/ \$4,500 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	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 <u>network providers</u> . For alcoholism or chemical dependency <u>providers</u> , call the Assistance Recovery Program (ARP) at (800) 562-3277.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network providers</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 <u>specialists</u> .	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> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	Not Covered	None
	<u>Specialist</u> visit	\$10/visit	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No charge for immunizations; No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (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 <u>prescription drug coverage</u> 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 <u>formulary</u> 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 <u>formulary</u> 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 <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.
	<u>Specialty drugs</u>	\$10 retail prescription	Not Covered	Up to 30-day retail. No charge contraceptives in accordance with <u>formulary</u> 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	<u>Emergency room care</u>	\$25/visit	Covered under HMO benefit	Must notify KP within 48 hours if admitted to a non <u>plan provider</u> ; Limited to initial emergency only
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered under HMO benefit	None
	<u>Urgent care</u>	\$10/visit; 20% <u>coinsurance</u> (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 ARP: No Charge	Not Covered	Additional substance abuse benefits are available through Assistance Recovery Program (ARP).
	Inpatient services	Kaiser: No Charge ARP: No charge	Kaiser and ARP: Not Covered	<u>Preauthorization</u> by ARP is required if you are not Medicare eligible.
If you are pregnant	Office visits	No Charge/Confirmed pregnancy	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	Delivery: No Charge.	Not Covered	No Charge, newborn inpatient
	Childbirth/delivery facility services	Delivery: No Charge.	Not Covered	No Charge, newborn inpatient

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	<u>Home health care</u>	No Charge	Not Covered	Physician visit covered at primary care visit copay
	<u>Rehabilitation services</u>	No Charge (inpatient); \$10/visit (outpatient)	Not Covered	None
	<u>Habilitation services</u>	Not covered	Not Covered	No coverage for habilitation
	<u>Skilled nursing care</u>	No Charge	Not Covered	Limited to 120 days/benefit period
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> diabetes equipment	Not Covered	20% for all other equipment
	<u>Hospice service</u>	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	If you elect additional vision coverage, it will be available under a separate vision <u>plan</u> .
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If you elect dental coverage, it will be available under the low option or high option separate dental <u>plan</u> .

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.)		
<ul style="list-style-type: none"> ● Acupuncture ● Chiropractic Care ● Cosmetic Surgery ● Dental care (Adult) 	<ul style="list-style-type: none"> ● Dental check-up (Child) ● Glasses ● Habilitation services ● Long-Term/Custodial Nursing Home Care 	<ul style="list-style-type: none"> ● 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.)		
<ul style="list-style-type: none"> ● Bariatric Surgery ● Hearing Aids (Every 3 years) 	<ul style="list-style-type: none"> ● Infertility Treatment 	<ul style="list-style-type: none"> ● 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 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	1-808-432-5955 (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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwijigo 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)	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)
■ The <u>plan's overall deductible</u> \$0	■ The <u>plan's overall deductible</u> \$0	■ The <u>plan's overall deductible</u> \$0
■ <u>Specialist copayment</u> \$10	■ <u>Specialist copayment</u> \$10	■ <u>Specialist copayment</u> \$10
■ <u>Hospital (facility) copayment</u> \$0	■ <u>Hospital (facility) copayment</u> \$0	■ <u>Hospital (facility) copayment</u> \$0
■ <u>Other (blood work) copayment</u> \$0	■ <u>Other (blood work) copayment</u> \$0	■ <u>Other (x-ray) copayment</u> \$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*)
 Durable medical equipment (*crutches*)
 Diagnostic test (*x-ray*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copays	\$0	Copays	\$500	Copays	\$80
Coinsurance	\$0	Coinsurance	\$900	Coinsurance	\$200
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$50	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$50	The total Joe would pay is	\$1,460	The total Mia would pay is	\$280

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