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?	**$2,500** Individual/ **$7,500** 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	$20/visit	Not Covered	None
	Specialist visit	$20/visit	Not Covered	None
	Preventive care/ screening/ immunization	No charge for immunizations; No Charge	Not Covered	No charge coverage per PPACA mandated services guidelines. Not subject to the overall deductible. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10/day (basic)	Not Covered	Lab: 20% coinsurance (specialty); Xray: 20% coinsurance (specialty)
	Imaging (CT/PET scans, MRI's)	20% coinsurance	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 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	$3 Maintenance Generic. 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	$45 retail; $90 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	$45 retail; $90 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	$200 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	None
	Physician/surgeon fees	10% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$100/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	$20/visit; 20% coinsurance (out of area)	Covered under HMO benefit	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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	None
	Physician/surgeon fee	10% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	Not Covered	None
	Inpatient services	10% coinsurance	Not Covered	None
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: 10% coinsurance.	Not Covered	10% coinsurance, newborn inpatient
	Childbirth/delivery facility services	Delivery: 10% coinsurance.	Not Covered	10% coinsurance, 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	10% coinsurance (inpatient); $20/visit (outpatient)	Not Covered	None
	Habilitation services	Not covered	Not Covered	No coverage for habilitation
	Skilled nursing care	10% coinsurance	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

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 your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	No Charge	Not Covered	Limited to 1 pair of lenses (polycarbonate single vision, lined bifocal or lined trifocal) and 1 frame (from the value collection frames) /calendar year
	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.)		
• Cosmetic Surgery • Dental care (Adult) • Dental check-up (Child)	• Habilitation services • Long-Term/Custodial Nursing Home 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.)		
• Acupuncture (Limited to 12 combined visits/ calendar year from American Specialty Health Network) • Bariatric Surgery	• Chiropractic Care (Limited to 12 combined visits/calendar year from American Specialty Health Network) • Hearing Aids (Every 3 years)	• 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 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, 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	$20
Hospital (facility) coinsurance	10%
Other (blood work) copayment	$10

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$960**

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	10%
Other (blood work) copayment	$10

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$1,100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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	10%
Other (x-ray) copayment	$10

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copays	$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.

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**).

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke loaʻa 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.

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

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk 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'dęę', 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 ʻoku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo 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**).