

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021



Coverage for: Individual / Family | Plan Type: HMO



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, provider, 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 <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 <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 <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> ?	\$2,500 Individual/ \$7,500 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> ?	Premiums, 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> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider 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 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> .



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 <u>Specialist</u> visit	\$15/visit \$15/visit	Not Covered Not Covered	\$0 for children ages 0-17 for routine/primary care. 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 preventive. Ask your <u>provider</u> if the services needed 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)	Lab: \$15/day (basic); Xray: \$15/day	Not Covered	Lab: 20% <u>coinsurance</u> (specialty); Inpatient fee included in Hospital stay;
	Imaging (CT/PET scans, MRI's)	20% <u>coinsurance</u>	Not Covered	None
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	\$3 Maintenance Generic. 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	\$45 retail; \$90 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	\$45 retail; \$90 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>	\$200 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) Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u> <u>Emergency medical transportation</u> <u>Urgent care</u>	\$100/visit 20% <u>coinsurance</u> \$15/visit; \$15 IN-AREA / 20% <u>coinsurance</u> (out of area)	Covered under HMO benefit Covered under HMO benefit Covered under HMO benefit	Must notify KP within 48 hours if admitted to a <u>non plan provider</u> ; Limited to initial emergency only
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	10% <u>coinsurance</u> 10% <u>coinsurance</u>	Not Covered Not Covered	None None
If you need mental health, behavioral health, or substance abuse services	Outpatient services Inpatient services	\$15/visit 10% <u>coinsurance</u>	Not Covered Not Covered	None None
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	No Charge/Confirmed pregnancy Delivery: No Charge. Delivery: No Charge.	Not Covered Not Covered 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.) 10% <u>coinsurance</u> , newborn inpatient 10% <u>coinsurance</u> , 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>	10% <u>coinsurance</u> (inpatient); \$15/visit (outpatient)	Not Covered	None
	<u>Habilitation services</u>	Not covered	Not Covered	No coverage for habilitation
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	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
	Children's eye exam	No Charge	Not Covered	\$0 for children ages 0-17 for routine/primary care
	Children's glasses	No Charge	Not Covered	Only 1 annual visit for eye exam covered at no charge. Hardware limited to 1 frame and lenses (selected styles), or 1 set of contacts per contract period.
	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.)

- Children's dental check-up
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling Outside the U.S.

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)
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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.ccio.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, kwiiijo 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 plan's overall deductible	\$0	The plan's overall deductible	\$0	The plan's overall deductible	\$0
Specialist copayment	\$15	Specialist copayment	\$15	Specialist copayment	\$15
Hospital (facility) coinsurance	10%	Hospital (facility) coinsurance	10%	Hospital (facility) coinsurance	10%
Other (blood work) copayment	\$15	Other (blood work) copayment	\$15	Other (x-ray) copayment	\$15
This EXAMPLE event includes services like: <u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay: <u>Cost Sharing</u>		In this example, Joe would pay: <u>Cost Sharing</u>		In this example, Mia would pay: <u>Cost Sharing</u>	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10	<u>Copayments</u>	\$900	<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$300	<u>Coinsurance</u>	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$10	The total Joe would pay is	\$1,200	The total Mia would pay is	\$700

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 fonoow. Foosun Chuuk, iwe en mei tongen omw kopwe angei anisinsin chiakku, ese kamo. Kori **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 loa'a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: 711).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti illokano, dagiti awan bayadha a serbisio a para iti beddeng ti lenguahe ket sidaaan 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: 한글어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: 711)번으로 전화해 주십시오.
ລາວ (Laotian) ໃບຕະຫຼານ: ຖ້າວາ ຫ້າມເວົ້າພາສາ ລາວ, ການປໍລິການຂວຍເຫຼືອດານພາສາ, ໂດຍບໍ່ສັງເກົາ, ໝົມນີ້ພອມໃຫ້ການ. ໂທຣ **1-800-966-5955** (TTY: 711).

Kajin Majōi (Marshallese) LALE: Ñe kwōj Kōnono Kajin Majōi, kwomaroñ bōk jerbal in jipāñ ilo kajin ñe am ejjejōk wōnāān. Kaalqok **1-800-966-5955** (TTY: 711).

Naabeehó (Navajo) Díí baa ákó nínizín: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ániда'áwo'déé', t'áá jiik'eh, éí ná hólq, kojj' hódiñnih **1-800-966-5955** (TTY: 711).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaiak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: 711).

Faa-Samoan (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auauanga 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 'oku ke Lea Faka-Tonga, ko e kau tokoni fakatou lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o 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).