



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

<https://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-966-5955 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
<a href="#">What is the overall deductible?</a>	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
<a href="#">Are there services covered before you meet your deductible?</a>	Not Applicable.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$2,500 Individual/ \$7,500 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	Premiums, health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-966-5955 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a specialist?</a>	Yes, but you may self-refer to certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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	\$15/visit	Not Covered	No charge for children through age 17.
	<a href="#">Specialist</a> visit	\$15/visit	Not Covered	None
	<a href="#">Preventive care/ screening/ immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab: \$15/day (basic); Xray: \$15/day	Not Covered	Lab: 20% <a href="#">coinsurance</a> (specialty);
	Imaging (CT/PET scans, MRI's)	20% <a href="#">coinsurance</a>	Not Covered	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	\$10 retail; \$20 mail order/ <a href="#">prescription</a>	Not Covered	\$3 Maintenance Generic. Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with <a href="#">formulary</a> guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	\$45 retail; \$90 mail order/ <a href="#">prescription</a>	Not Covered	Up to 30-day retail or 90-day mail order. Subject to <a href="#">formulary</a> guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	\$45 retail; \$90 mail order/ <a href="#">prescription</a>	Not Covered	Up to 30-day retail or 90-day mail order. Subject to <a href="#">formulary</a> guidelines. Certain drugs may be covered at a different cost share.
	<a href="#">Specialty drugs</a>	\$200 retail <a href="#">prescription</a>	Not Covered	Up to 30-day retail. Certain drugs may be covered at a different cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	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 immediate medical attention	<a href="#">Emergency room care</a>	\$100/visit	\$100/visit	Must notify KP within 48 hours if admitted to a <a href="#">non plan provider</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$15/visit	Not Covered	<a href="#">Non-plan providers</a> covered when temporarily outside the service area: 20% <a href="#">coinsurance</a>
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fee	10% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15/visit	Not Covered	Mental/Behavioral health: No charge for children through age 17.; Substance abuse: None
	Inpatient services	10% <a href="#">coinsurance</a>	Not Covered	None
If you are pregnant	Office visits	No charge	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> 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	Professional services are included in the facility services
	Childbirth/delivery facility services	No charge	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 help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not Covered	Physician visit covered at primary care visit copay
	<a href="#">Rehabilitation services</a>	\$15/visit (outpatient); 10% <a href="#">coinsurance</a> (inpatient).	Not Covered	None
	<a href="#">Habilitation services</a>	Not covered	Not Covered	None
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not Covered	Limited to 120 days/benefit period
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> ; 50% <a href="#">coinsurance</a> for Diabetic Supplies and Equipment	Not Covered	Subject to <a href="#">formulary</a> guidelines.
	<a href="#">Hospice service</a>	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	Not Covered	Not Covered	None
	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](#).)

- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental care (Adult)
- [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 (20 visit limit / year combined with Chiropractic care)
- Bariatric Surgery
- Chiropractic Care (20 visit limit / year combined with Acupuncture)
- 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](http://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 <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.ccio.cms.gov">www.ccio.cms.gov</a>
Hawaii Department of Insurance	1-808-586-2790 or <a href="http://cca.hawaii.gov/ins/">http://cca.hawaii.gov/ins/</a>

#### 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, kwijjigo 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, á'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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$15
<a href="#">Hospital (facility) copayment</a>	\$0
<a href="#">Other (blood work) copayment</a>	\$15

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$0

What isn't covered

Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$20</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$15
<a href="#">Hospital (facility) coinsurance</a>	10%
<a href="#">Other (blood work) copayment</a>	\$15

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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$400

What isn't covered

Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$800</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$15
<a href="#">Hospital (facility) coinsurance</a>	10%
<a href="#">Other (x-ray) copayment</a>	\$15

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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200

What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>

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).

**‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI:** Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke nā lawelawe kōkua ‘ōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi ‘ole, loa‘a 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) ເອົ້າໃຈໃສ່:** ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສີມ ຈະມີໃຫ້ທ່ານໄດ້ຍິ່ງເສຍຄ້າ. ໂທ **1-800-966-5955** (TTY: 711).

**Kajin Majōl (Marshallese) Roñjake:** Ñe kwōjeļā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jerbal ko jet, ejjeļok onāāer, repellok ñan eok. Kūr tok **1-800-966-5955** (TTY: 711).

**Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN:** Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojí' hódíílnih **1-800-966-5955** (TTY: 711).

**Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR:** Ma komw kin lokaiahn 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**).

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