This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling Kaiser Permanente at **808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**KP:** $0 **Non-KP:** Self **$100** / Self + Family **$300**	See chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes** **KP (Tier I):** Self: **$2,000/** Self + Family**: $6,000** **Non-KP (Tiers II & III):** Self **$2,000 /** Self + Family **$6,000**	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**KP**: Premiums, balance billed charges and health care this plan doesn't cover. **Non-KP**: Precertification penalties, premiums, balance-billed charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, **KP** HMO and **Non-KP** Contracted Providers. See http://my.kp.org/lowes or call **1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands)** for KP HMO Plan providers and Non-KP Contracted providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating, for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**KP**: Yes for KP Plan providers only (written approval is required to see most specialists) **Non-KP**: No	KP: This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. Non-KP: You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if a out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		KP Plan Provider (HMO)	Contracted Provider (CON)	Noncontracted Provider (NonCON)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	20% coinsurance of contracted rate	20% coinsurance of allowable charge	----------none----------
	Specialist visit	$20 per visit	20% coinsurance of contracted rate	20% coinsurance of allowable charge	----------none----------
	Other practitioner office visit	Not covered	Not Covered	Not Covered	----------none----------
	Preventive care/ screening/immunization	No Charge/primary care visit. No charge for immunizations	No Charge	No Charge	KP and Non-KP (CON): All PPACA mandated services are covered at no charge (NonCON: Covered at no charge up to the allowed amount). All other services will be covered at the applicable cost share.
If you have a test	Diagnostic test (x-ray, blood work)	Lab/Xray: $10/day	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Lab/Xray - Inpatient fee included in hospital stay. 20% coinsurance (specialty lab/xray outpatient)
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Inpatient fee included in hospital stay, Non-KP: Precertification required for CON and NonCON providers. Failure to pre-certify may result in a penalty up to $300 per occurrence.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		KP Plan Provider (HMO)	Contracted Provider (CON)	Noncontracted Provider (NonCON)	
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	$15 retail $30 mail order/prescription	20% coinsurance, not less than $15 copay	Not Covered	KP: $5 maintenance generic; Covers up to a 30-day supply retail or up to 90-day supply mail order; no charge contraceptives per formulary; Non-KP: No charge for contraceptives per PPACA up to the allowed amount. Not available through mail order.
	Preferred brand drugs	$50 retail $100 mail order/ prescription	20% coinsurance, not less than $50 copay	Not Covered	
	Non-preferred brand drugs	$50 retail $100 mail order/ prescription	20% coinsurance, not less than $50 copay	Not Covered	
	Specialty drugs	$75 retail	20% coinsurance, not less than $75 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: none; Non-KP: Precertification required for CON and NonCON. Failure to pre-certify may result in a penalty up to $300 per occurrence.
	Physician/surgeon fees				
If you need immediate medical attention	Emergency room services	$100 per visit	Emergencies covered under HMO benefit	Emergencies covered under HMO benefit	KP to be notified of CON and NonCON within 48 hours. Limited to initial emergency only. Copay waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance	Emergencies covered under HMO benefit	Emergencies covered under HMO benefit	Non-KP: Scheduled transportation covered at 20% of allowable charges.
	Urgent care	$20 per visit (in area); 20% coinsurance (out of area)	Urgent care covered under HMO benefit	Urgent care covered under HMO benefit	Non-KP: Covered subject to 20% coinsurance of allowable charge when not covered by KP as an HMO benefit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: none; Non-KP: Precertification required for CON and NonCON. Failure to pre-certify may result in a penalty up to $300 per occurrence.
	Physician/surgeon fee				

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		KP Plan Provider (HMO)	Contracted Provider (CON)	Noncontracted Provider (NonCON)	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per visit	20% coinsurance of contracted rate	20% coinsurance of allowable charge	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: none; Non-KP: Precertification required for CON and NonCON providers. Failure to pre-certify may result in a penalty up to $300 per occurrence.
	Substance use disorder outpatient services	$20 per visit	20% coinsurance of contracted rate	20% coinsurance of allowable charge	----------none----------
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: none; Non-KP: Precertification required for CON and NonCON providers. Failure to pre-certify may result in a penalty up to $300 per occurrence.
If you are pregnant	Prenatal and postnatal care	No charge/ confirmed pregnancy	0% coinsurance of contracted rate	0% coinsurance of allowable charge	KP and Non-KP: Routine care covered at no charge. All other care, such as complications of pregnancy and false labor, is covered at the applicable copay or coinsurance.
	Delivery and all inpatient services	Delivery: 10% coinsurance.	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: 10% coinsurance Newborn inpatient.
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Physician visit covered at primary care visit copay; Non-KP: Limited to 150 visits per calendar year combined for CON and NonCON providers. Private duty nursing not covered.
	Rehabilitation services	10% coinsurance (inpatient), $20 per visit (outpatient)	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: none; Non-KP: For CON and NonCON: Maximum of 60 outpatient visits per calendar year combined for Physical, Speech & Occupational Therapy. Precertification required. Failure to pre-certify may result in a penalty up to $300 per occurrence.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		KP Plan Provider (HMO)	Contracted Provider (CON)	Noncontracted Provider (NonCON)	
	Habilitation services	Not Covered	Not Covered	Not Covered	----------none----------
	Skilled nursing care	10% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Limited to 120 days/ benefit period; Non-KP: CON and NonCON: Precertification required. Failure to pre-certify may result in a penalty up to $300 per occurrence. Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance; except diabetes equipment covered at 50% coinsurance	20% coinsurance of contracted rate	20% coinsurance of allowable charge	Non-KP: CON and NonCON providers: Please see plan terms for specific limits and terms. Precertification required. Failure to pre-certify may result in a penalty up to $300 per occurrence.
	Hospice service	No Charge	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Includes two 90-day periods, followed by unlimited number 60-day periods; Non-KP: CON and NonCON providers: Limited to a combined maximum of 210 days while insured. Precertification required. Failure to pre-certify may result in a penalty up to $300 per occurrence.
If your child needs dental or eye care	Eye exam	$20 per visit	20% coinsurance of contracted rate	20% coinsurance of allowable charge	KP: Limited to one eye exam per calendar year.
	Glasses	Not Covered	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	Not Covered	No coverage for dental exams

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Chiropractic Care
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (without diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery (covered by KP Plan providers only) • Hearing aids	• Infertility Treatment, with limitations	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Kaiser Permanente at 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or online at http://www.kp.org/memberservices. For Participating and Nonparticipating providers, you can contact Dell Health Services by calling 1-800-392-8649. Additionally, you may contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the State of Hawaii Department of Commerce and Consumer Affairs at: Hawaii Insurance Division Health Insurance Branch PO Box 3614 Honolulu, HI 96811 or call 1-808-586-2804 for the Hawaii Insurance Division of the Department of Commerce and Consumer Affairs.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-808-432-5955 (Oahu) or 1-800-966-5955 (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 (Oahu) or 1-800-966-5955 (Neighbor islands).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations from a KP Plan provider. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

All care is in-network and considered first tier (or the tier associated with the lowest level of cost sharing), for those products that incorporate tiered provider networks.. No out-of-network charges or any other variation in Sample Care Costs.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,910
- **Patient pays** $630

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$400
Limits or exclusions	$200
Total	**$630**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$800
Coinsurance	$600
Limits or exclusions	$80
Total	**$1,480**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.