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 my.kp.org or by calling 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See chart 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.** $2,500 Individual / $7,500 Family	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?	Premiums, balance-billed charges, and health care this plan doesn't 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.** See www.kp.org or call 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands)	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?	**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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 5. 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 an 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	Not Covered	---none---
	Specialist visit	$20 copayment per visit	Not Covered	---none---
	Other practitioner office visit	Not Covered	Not Covered	---none---
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge (inpatient); 10% coinsurance (outpatient)	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	No Charge (inpatient); 10% coinsurance (outpatient)	Not Covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non Plan Provider	Limitations & Exceptions
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	$5 copayment per prescription (maintenance); $15 copayment per prescription (generic)	Not Covered	Retail copayment for each 30-consecutive-day supply; Mail order copayment is twice the retail copayment for up to 90-consecutive-day supply); No charge for contraceptives (subject to formulary guidelines)
	Preferred brand drugs	$50 copayment per prescription (retail)	Not Covered	
	Non-preferred brand drugs	$50 copayment per prescription (retail)	Not Covered	
	Specialty drugs	$50 copayment per prescription (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copayment per visit	Not Covered	---none---
	Physician/surgeon fees			---none---
If you need immediate medical attention	Emergency room services	$75 copayment per visit (non plan provider covered when medical emergency)		Must notify KP within 48 hours if admitted to a non plan provider
	Emergency medical transportation	20% coinsurance		---none---
	Urgent care	$20 copayment per visit at KP HI facilities; 20% coinsurance for non-KP facility outside HI service area		---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copayment per day	Not Covered	---none---
	Physician/surgeon fee		Not Covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment per visit	Not Covered	---none---
	Mental/Behavioral health inpatient services	$75 copayment per day	Not Covered	---none---
	Substance use disorder outpatient services	$20 copayment per visit	Not Covered	---none---
	Substance use disorder inpatient services	$75 copayment per day	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	$20 copayment initial visit to confirm pregnancy. Limited to routine care.
	Delivery and all inpatient services	No Charge	Not Covered	For newborn: No Charge; $75 copayment per day for inpatient services
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	---none---
	Rehabilitation services	$20 copayment per visit (outpatient); $75 copayment per day (inpatient)	Not Covered	---none---
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	No Charge	Not Covered	60 day maximum per benefit period
	Durable medical equipment	20% coinsurance	Not Covered	50% coinsurance for Diabetic Equipment
	Hospice service	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	Eye exam	$20 copayment per visit	Not Covered	---none---
	Glasses	No Charge up to $150 allowance per calendar year	Not Covered	Patient covers costs greater than $150 allowance once every calendar year
	Dental check-up	No Charge up to $1200 allowance per calendar year	Not Covered	Plan pays 100% preventive examinations twice per calendar year. See your policy or plan document for additional information about services.

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
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Foot Care
- 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
- Dental care (Adult)
- Hearing Aids
- Glasses
- Infertility treatment
- 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.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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. 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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 7,220
- **Patient pays** $ 320

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	$ 120
Coinsurance	$ 50
Limits or exclusions	$ 150
Total	**$ 320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $ 3,870
- **Patient pays** $ 1,530

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	$ 650
Limits or exclusions	$ 80
Total	**$ 1,530**

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.