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

**Kaiser Permanente**: Leidos – Hawaii

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**Coverage Period**: 01/01/2020 – 12/31/2020

**Coverage for**: Individual / Family | Plan Type: HMO

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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 https://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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Not Applicable.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,000 Individual / $6,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands for a list of plan providers.</td>
<td>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 provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, but you may self-refer to certain specialists.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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*Note: This summary is intended to provide a general overview of the plan's benefits and coverage. For specific details, please refer to the full SBC document available at www.kp.org/plandocuments or call the provided contact numbers.*
**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **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 | **Plan Provider** (You will pay the least) $15 / visit | **Non-Plan Provider** (You will pay the most) Not covered
Specialist visit | $15 / visit | Not covered
Preventive care/screening/ immunization | No charge | Not covered

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% coinsurance | None
Imaging (CT/PET scans, MRIs) | 10% coinsurance | None

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
Preferred brand drugs | $35 (retail); $70 (mail order) / prescription | Not covered
Non-preferred brand drugs | Same as Preferred brand drugs | Not covered
Specialty drugs | $200 (retail) / prescription | Not covered

Maintenance Generic: $3 (retail); $6 (mail order). Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge for contraceptives. Subject to formulary guidelines.
Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge for contraceptives. Subject to formulary guidelines.
Same as Preferred brand drugs, when approved through the exception process.
Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.

If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $15 / visit | None
Physician/surgeon fees | Included in Facility fee | Not covered

If you need immediate medical attention | Emergency room care | $50 / visit | $50 / visit
Emergency medical transportation | 20% coinsurance | 20% coinsurance

Must notify KP within 48 hours if admitted to a non-plan provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td>Non-Plan Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Urgent care</td>
<td>$15 / visit</td>
<td>$15 / visit</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$50 / day</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Outpatient: $15 / visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>No charge for refractive exam</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & child)
- Habilitation services
- Long-term care/Custodial Nursing Home
- Non-emergency care when traveling 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.)

- Bariatric surgery
- Hearing aids (1 aid / ear / 36 months)
- Infertility treatment (1 in vitro procedure limit / lifetime)
- 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 agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeal Rights:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Member Services</td>
<td>1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a></td>
<td></td>
</tr>
<tr>
<td>Department of Labor’s Employee Benefits Security Administration</td>
<td>1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Human Services, Center for Consumer Information &amp; Insurance Oversight</td>
<td>1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a></td>
<td></td>
</tr>
<tr>
<td>Hawaii Department of Insurance</td>
<td>1-808-586-2790 or <a href="http://cca.hawaii.gov/ins/">http://cca.hawaii.gov/ins/</a></td>
<td></td>
</tr>
</tbody>
</table>

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, kwiijogo 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: $0
- Hospital (facility) copayment: $0
- Other (blood work) coinsurance: 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td>$150</td>
</tr>
</tbody>
</table>

### 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: $15
- Hospital (facility) copayment: $50
- Other (blood work) coinsurance: 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$200</td>
</tr>
<tr>
<td><strong>The total Joe would pay is</strong></td>
<td>$1,860</td>
</tr>
</tbody>
</table>

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $0
- Specialist copayment: $15
- Hospital (facility) copayment: $50
- Other (x-ray) coinsurance: 10%

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**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td>$300</td>
</tr>
</tbody>
</table>

The plan would be responsible for the other costs of these EXAMPLE covered services.
NONDISCRIMINATION NOTICE

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- 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

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）。


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).

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).