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 or by calling 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person/ **$3,000** family Preventive care services, office visits and prescription drugs do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Brand and specialty prescription drugs: **$ 250** person/**$ 500** family in network. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	For **preferred providers** **$6,350** person / **$12,700** 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, Copayments (not applicable), balance-billing 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. For a list of **preferred providers**, see www.kp.org **or call 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. 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 4. 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay	Not Covered	Except post op visits are covered at no charge
	Specialist visit	$40 Copay	Not Covered	Except post op visits are covered at no charge
	Other practitioner office visit	$30 Copay	Not Covered	Except post op visits are covered at no charge
	Preventive care/screening/immunization	No Charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay	Not Covered	$30/day (basic, outpatient) not subject to deductible, $300/day (special, outpatient) after deductible, Inpatient included in hospital facility fee.
	Imaging (CT/PET scans, MRIs)	$300 Copay after deductible	Not Covered	$300 per day after deductible (outpatient); No Charge (inpatient)
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	Retail:$15 Copay Mail Order:$30 Copay	Not Covered	Generic maintenance: $5 for 30-day retail, $10 for 90-day mail; Generic: $15 for 30-day retail, $30 for 90-day mail; no charge female contraceptives (per formulary guidelines)
	Preferred brand drugs	50% Coinsurance after deductible	Not Covered	After $250 drug deductible; no charge for female contraceptives (subject to formulary guidelines)
	Non-preferred brand drugs	50% Coinsurance after deductible	Not Covered	After $250 drug deductible; no charge for female contraceptives (subject to formulary guidelines)

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Specialty drugs	50% Coinsurance after deductible	Not Covered	After $250 drug deductible; no charge for female contraceptives (subject to formulary guidelines)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	Not Covered	——————none——————
	Physician/surgeon fees	20% Coinsurance after deductible	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	20% Coinsurance after deductible	20% Coinsurance after deductible	Must notify KP within 48 hours if admitted to a non-plan provider; limited to initial emergency only
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	——————none——————
	Urgent care	20% Coinsurance	20% Coinsurance	20% for urgent care outside the Hawaii service area, except $30/visit primary urgent care and $40/visit specialists urgent care within Hawaii service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	Not Covered	——————none——————
	Physician/surgeon fee	20% Coinsurance after deductible	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 Copay	Not Covered	$30/visit primary care, $40/visit specialist
	Mental/Behavioral health inpatient services	20% Coinsurance after deductible	Not Covered	——————none——————
	Substance use disorder outpatient services	$30 Copay	Not Covered	$30/visit primary care, $40/visit specialist
	Substance use disorder inpatient services	20% Coinsurance after deductible	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	After confirmation of pregnancy, coverage is limited to routine care.
	Delivery and all inpatient services	20% Coinsurance after deductible	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	————————none————————
	Rehabilitation services	Inpatient:20% Coinsurance after deductible Outpatient:$30 Copay	Not Covered	————————none————————
	Habilitation services	$30 Copay	Not Covered	Inpatient: 20% coinsurance after deductible
	Skilled nursing care	20% Coinsurance after deductible	Not Covered	Limited to 60 days per Benefit Period
	Durable medical equipment	20% Coinsurance	Not Covered	Except 50% coinsurance for state mandated diabetes equipment
	Hospice service	No Charge	Not Covered	Coverage is limited to two 90-day periods, followed by an unlimited number of 60-day periods
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per calendar year
	Glasses	No Charge	Not Covered	Limited to one pair of lenses (polycarbonate single vision, lined bifocal or lined trifocal) and one frame (from the "value collection frames") per calendar year
	Dental check-up	Not Covered	Not Covered	————————none————————

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
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling Outside the U.S.
- Private-Duty Nursing
- Routine Dental Services (Adult)
- 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 with limits • Hearing Aids with limits	• Infertility Treatment with limits • Routine Eye Exam (Adult) with limits	• Routine Hearing Tests with limits

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands). You may also contact your state insurance department at 808-586-2790.

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: 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **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 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or TTY/TDD 1-877-447-5990

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or TTY/TDD 1-877-447-5990

CHINESE: 若有問題：請撥打808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) 或 TTY/TDD 1-877-447-5990

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or TTY/TDD 1-877-447-5990

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** $4,120
- **Patient pays** $3,420

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	$2,400
Co-pays	$ 20
Co-insurance	$ 800
Limits or exclusions	$ 200
Total	**$3,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

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
Co-pays	$ 600
Co-insurance	$ 600
Limits or exclusions	$ 80
Total	**$1,280**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.