Kaiser Permanente for Individuals and Families

KAISER PERMANENTE®

Healthy together

Care and coverage that fits your life

buykp.org

2020 Enrollment | Hawaii

Welcome to care that fits your life

This Kaiser Permanente for Individuals and Families enrollment guide can help you choose the right health plan for your needs. Here's a look at what you'll get with all of our plans.

Right care, right time

Get the care you need when you need it with routine, specialty, urgent, and emergency care. If you're ever unsure where to go, call us for 24/7 care advice by phone.

Many services under one roof

Do more in less time. In most of our facilities, you can see your doctor, get a lab test, and pick up prescriptions – all in a single trip. Find a location near you at **kp.org/facilities**.

Your doctor, your choice

Choose your doctor based on what's important to you. Go to **kp.org/searchdoctors** for details about education, specialties, languages spoken, and more. You can also change doctors at any time.

More care options

How you get care is up to you. Choose a phone appointment or video visit,[1] email your doctor's office with nonurgent questions, or come see us in person.[2]

Earn a free gym membership

Visit **kp.org/fitrewards** for details on how you can earn your annual gym membership fee back.

[1]When appropriate and available.
[2]These features are available when you get care at Kaiser Permanente facilities.

Choosing your health plan

We offer a variety of plans to fit your needs and budget. All of them offer the same quality care, but the way they split the costs is different.

Copay and coinsurance plans – platinum and gold

Copay and coinsurance plans are the simplest. You know in advance how much you'll pay for care like doctor visits and prescriptions. This amount is called your copay. Your monthly premium is higher, but you'll pay much less when you get care.

Deductible plans – gold, silver, and bronze

With a deductible plan, your monthly premium is lower, but you'll need to pay the full charges for most covered services until you reach a set amount, known as your deductible. Then you'll start paying less – a copay or coinsurance. Depending on your plan, some services, like office visits or prescriptions, may be available at a copay or coinsurance before you reach your deductible.

*For a complete list of services you can use your HSA to pay for, see Publication 502, Medical and Dental Expenses, at irs.gov.

Example of your costs for care

Let's say you hurt your ankle. You visit your personal doctor, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication. Here's an example of what you'd pay out of pocket for these services with each type of health plan.

Plan name	Office visit	X-ray	Generic drug
KP HI Gold 0/30 (no deductible)	$30	$30	$10 generic/$3 generic maintenance
KP HI Silver 2500/40 ($2,500 deductible)	$40	$40	$20* generic/$3* generic maintenance
KP HI Bronze 6500/60 ($6,500 deductible)	$60	$60	$30* generic/$3* generic maintenance

*After you reach your deductible.

The cost estimates above are from **kp.org/treatmentestimates**. Visit this site anytime to get an idea of what the charges for common services might be before you reach your deductible.

Important open enrollment dates for 2020

- The open enrollment period for 2020 coverage runs from **November 1, 2019**, through **December 15, 2019.**
- You can change or apply for coverage through Kaiser Permanente, or we can help you apply through the Health Insurance Marketplace.
- For coverage that starts on January 1, 2020, we must receive your Application for Health Coverage and first month's premium no later than December 15, 2019.

Enrolling during a special enrollment period

- Are you getting married, having a baby, or losing your health coverage? You can also enroll or change your coverage at other times throughout the year if you have a qualifying life event.
- Visit **kp.org/specialenrollment** for a list of qualifying life events and instructions.

Do you qualify for financial help?

You may be eligible for federal or state financial assistance to help you pay for care or coverage. Visit **healthcare.gov.** for details.

Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

Understanding the plans: benefit highlights

The charts on the next few pages show you a sample of each plan's benefits. Review the diagram below to help you understand how to read those charts.

Here's a quick look at how to use the chart

	KP M KP HI Silver 4000/45
Plan type	Copayment
Features	
Annual medical deductible (individual/family)	$4,000/$8,000
Annual out-of-pocket maximum (individual/family)	$8,000/$16,000
Benefits	
Preventive care	
Routine physical exam, mammograms, etc.	No charge
Outpatient services (per visit or procedure)	
Primary care office visit	$45
Specialty care office visit	$65
Most X-rays	$45
Most lab tests	$45
MRI, CT, PET	$350 after deductible
Outpatient surgery	30% after deductible
Mental health visit	$45
Inpatient hospital care	
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible
Maternity	
Routine prenatal care visit, first postpartum visit	No charge
Delivery and inpatient well-baby care	30% after deductible
Emergency and urgent care	
Emergency Department visit	30% after deductible
Urgent care visit	20% applicable charges/ $45 primary or $65 specialty
Prescription drugs (up to a 30-day supply)	
Generic	$20* generic/ $3* generic maintenance
Preferred brand	50% after $500 pharmacy deductible
Non-preferred brand	50% after $500 pharmacy deductible
Specialty	50% after $500 pharmacy deductible
Whole health	
Healthy services	KP Fit Rewards

KP Offered through Kaiser Permanente

M Offered through the Health Insurance Marketplace

Annual deductible

You need to pay this amount before your plan starts helping you pay for most covered services. Under this sample plan, you'd pay the full charges for covered services until you reach $4,000 for yourself or $8,000 for your family. Then you'd start paying copays or coinsurance.

Annual out-of-pocket maximum

This is the most you'll pay for care during the calendar year before your plan starts paying 100% for most covered services. In this example, you'd never pay more than $8,000 for yourself and no more than $16,000 for your family for your copays, coinsurance, and deductible in a calendar year.

Preventive care at no charge

Most preventive care services—including routine physical exams and mammograms—are covered at no charge. Plus, they're not subject to the deductible.

Covered before you reach the deductible

With some services, you'll only pay a copay or coinsurance, regardless of whether you've reached your deductible. Under this plan, primary care visits are covered at a $45 copay—even before you meet your deductible. With our Silver deductible plans, primary care, specialty care, and urgent care visits all are covered before you reach the deductible.

Coinsurance

After reaching your deductible, this is a percentage of the charges that you may pay for covered services. Here, you'd pay 30% of the cost per day for your inpatient hospital care after you reach your deductible. Your plan would pay the rest for the remainder of the calendar year.

Copay

This is the set amount you pay for covered services, usually after you reach your deductible. In this example, you'd pay a 20% applicable charges/ $45 primary or $65 specialty copay for urgent care visits, whether or not you have met your deductible.

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	KP M KP HI Bronze 5500/30% KP HI Bronze 5500/30% Off	KP M KP HI Bronze 6500/60 KP HI Bronze 6500/60 Off	KP M KP HI Silver 4000/45 KP HI Silver 4000/45 Off
Plan type	**HSA-qualified**	**Deductible**	**Deductible**
Features			
Annual medical deductible (individual/family)	$5,500/$11,000	$6,500/$13,000	$4,000/$8,000
Annual out-of-pocket maximum (individual/family)	$7,000/$14,000	$8,150/$16,300	$8,000/$16,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	30% after deductible	$60	$45
Specialty care office visit	30% after deductible	$120	$65
Most X-rays	30% after deductible	$60	$45
Most lab tests	30% after deductible	$60	$45
MRI, CT, PET	30% after deductible	40% after deductible	$350 after deductible
Outpatient surgery	30% after deductible	40% after deductible	30% after deductible
Mental health visit	30% after deductible	$60	$45
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	40% after deductible	30% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	40% after deductible	30% after deductible
Emergency and urgent care			
Emergency Department visit	30% after deductible	40% after deductible	30% after deductible
Urgent care visit	30% after deductible	20% applicable charges/ $60 primary or $120 specialty	20% applicable charges/ $45 primary or $65 specialty
Prescription drugs (up to a 30-day supply)			
Generic	30% after deductible	$30* generic/$3* generic maintenance	$20* generic/$3* generic maintenance
Preferred brand	30% after deductible	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible
Non-preferred brand	30% after deductible	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible
Specialty	30% after deductible	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible
Whole health			
Healthy services	KP Fit Rewards**	KP Fit Rewards**	KP Fit Rewards**

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‡ Waived if admitted
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	KP M KP HI Silver 2500/40 KP HI Silver 2500/40 Off	KP M KP HI Gold 1000/30 KP HI Gold 1000/30 Off	KP M KP HI Gold 0/30 KP HI Gold 0/30 Off	KP M KP HI Platinum 0/10 KP HI Platinum 0/10 Off
Plan type	Deductible	Deductible	Deductible	Copayment
Features				
Annual medical deductible (individual/family)	$2,500/$5,000	$1,000/$2,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$8,000/$16,000	$7,600/$15,200	$7,600/$15,200	$5,500/$11,000
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$40	$30	$30	$10
Specialty care office visit	$60	$50	$50	$20
Most X-rays	$40	$30	$30	$10
Most lab tests	$40	$30	$30	$10
MRI, CT, PET	$300 after deductible	$250 after deductible	$350	$100
Outpatient surgery	30% after deductible	20% after deductible	30% coinsurance	$120
Mental health visit	$40	$30	$30	$10
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	$250 per day after deductible	30% coinsurance	$300 per day up to 4 days†
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	$250 per day after deductible	30% coinsurance	$300 per day up to 4 days†
Emergency and urgent care				
Emergency Department visit	30% after deductible	$250‡ after deductible	$350‡	$250‡
Urgent care visit	20% applicable charges/ $40 primary or $60 specialty	20% applicable charges/ $30 primary or $50 specialty	20% applicable charges/ $30 primary or $50 specialty	20% applicable charges/ $10 primary or $20 specialty
Prescription drugs (up to a 30-day supply)				
Generic	$20* generic/ $3* generic maintenance	$10* generic/ $3* generic maintenance	$10* generic/ $3* generic maintenance	$5* generic/ $3* generic maintenance
Preferred brand	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	$50	$45
Non-preferred brand	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	$50	$45
Specialty	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	$200	$200
Whole health				
Healthy services	KP Fit Rewards**	KP Fit Rewards**	KP Fit Rewards**	KP Fit Rewards** Optical $150 annually applied to hardware

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ChiroAcuMassage Plans

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	KP M KP HI Bronze 6500/60 Plus CAM KP HI Bronze 6500/60 Plus CAM Off	KP M KP HI Silver 2500/40 Plus CAM KP HI Silver 2500/40 Plus CAM Off	KP M KP HI Gold 0/30 Plus CAM KP HI Gold 0/30 Plus CAM Off	KP M KP HI Platinum 0/10 Plus CAM KP HI Platinum 0/10 Plus CAM Off
Plan type	**Deductible**	**Deductible**	**Copayment**	**Copayment**
Features				
Annual medical deductible (individual/family)	$6,500/$13,000	$2,500/$5,000	None/None	None/None
Annual out-of-pocket maximum (individual/family)	$8,150/$16,300	$8,000/$16,000	$7,600/$15,200	$5,500/$11,000
Benefits				
Preventive care				
Routine physical exam, mammograms, etc.	No charge	No charge	No charge	No charge
Outpatient services (per visit or procedure)				
Primary care office visit	$60	$40	$30	$10
Specialty care office visit	$120	$60	$50	$20
Most X-rays	$60	$40	$30	$10
Most lab tests	$60	$40	$30	$10
MRI, CT, PET	40% after deductible	$300 after deductible	$350	$100
Outpatient surgery	40% after deductible	30% after deductible	30% coinsurance	$120
Mental health visit	$60	$40	$30	$10
Inpatient hospital care				
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	40% after deductible	30% after deductible	30% coinsurance	$300 per day up to 4 days†
Maternity				
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge	No charge
Delivery and inpatient well-baby care	40% after deductible	30% after deductible	30% coinsurance	$300 per day up to 4 days†
Emergency and urgent care				
Emergency Department visit	40% after deductible	30% after deductible	$350‡	$250‡
Urgent care visit	20% applicable charges/ $60 primary or $120 specialty	20% applicable charges/ $40 primary or $60 specialty	20% applicable charges/ $30 primary or $50 specialty	20% applicable charges/ $10 primary or $20 specialty
Prescription drugs (up to a 30-day supply)				
Generic	$30* generic/ $3* generic maintenance	$20* generic/ $3* generic maintenance	$10* generic/ $3* generic maintenance	$5* generic/ $3* generic maintenance
Preferred brand	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible	$50	$45
Non-preferred brand	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible	$50	$45
Specialty	50% after $1,000 pharmacy deductible	50% after $500 pharmacy deductible	$200	$200
Whole health				
Healthy services	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year. Optical $150 annually applied to hardware

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ChiroAcuMassage Plans

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	KP M KP HI Silver 2500/40 CSR73 Plus CAM	M KP HI Silver 250/20 CSR87 Plus CAM	M KP HI Silver 0/10 CSR94 Plus CAM
Plan type	**Deductible**	**Deductible**	**Copayment**
Features			
Annual medical deductible (individual/family)	$2,500/$5,000	$250/$500	None/None
Annual out-of-pocket maximum (individual/family)	$6,350/$12,700	$2,700/$5,400	$2,500/$5,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$40	$20	$10
Specialty care office visit	$60	$40	$30
Most X-rays	$40	$20	$10
Most lab tests	$40	$20	$10
MRI, CT, PET	$300 after deductible	$150	$50
Outpatient surgery	30% after deductible	20% after deductible	10% coinsurance
Mental health visit	$40	$20	$10
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	20% after deductible	10% coinsurance
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	10% coinsurance
Emergency and urgent care			
Emergency Department visit	30% after deductible	20% after deductible	10% coinsurance
Urgent care visit	20% applicable charges/ $40 primary or $60 specialty	20% applicable charges/ $20 primary or $40 specialty	20% applicable charges/ $10 primary or $30 specialty
Prescription drugs (up to a 30-day supply)			
Generic	$20* generic/ $3* generic maintenance	$15* generic/ $3* generic maintenance	$5* generic/ $0* generic maintenance
Preferred brand	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Non-preferred brand	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Specialty	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Whole health			
Healthy services	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year	KP Fit Rewards**, Chiropractic, Acupuncture and Massage (CAM) $20 per visit; combined max 12 visits per year

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Cost Share Reduction (CSR) Plans

You must qualify for and enroll in the CSR plans on this page through healthcare.gov.

	M KP HI Silver 3500/40 CSR73	M KP HI Silver 750/10 CSR87	M KP HI Silver 50/5 CSR94
Plan type	Deductible	Deductible	Deductible
Features			
Annual medical deductible (individual/family)	$3,500/$7,000	$750/$1,500	$50/$100
Annual out-of-pocket maximum (individual/family)	$6,500/$13,000	$2,700/$5,400	$2,700/$5,400
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$40	$10	$5
Specialty care office visit	$60	$30	$25
Most X-rays	$45	$10	$10
Most lab tests	$45	$10	$10
MRI, CT, PET	$350 after deductible	$250	$25
Outpatient surgery	30% after deductible	20% after deductible	10% after deductible
Mental health visit	$40	$10	$5
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	20% after deductible	10% after deductible
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	10% after deductible
Emergency and urgent care			
Emergency Department visit	30% after deductible	20% after deductible	10% after deductible
Urgent care visit	20% applicable charges/ $40 primary or $60 specialty	20% applicable charges/ $10 primary or $30 specialty	20% applicable charges/ $5 primary or $25 specialty
Prescription drugs (up to a 30-day supply)			
Generic	$20* generic/ $3* generic maintenance	$15* generic/ $3* generic maintenance	$10* generic/ $3* generic maintenance
Preferred brand	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	5% coinsurance
Non-preferred brand	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	5% coinsurance
Specialty	50% after $500 pharmacy deductible	50% after $200 pharmacy deductible	5% coinsurance
Whole health			
Healthy services	KP Fit Rewards**	KP Fit Rewards**	KP Fit Rewards**

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Cost Share Reduction (CSR) Plans

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	M KP HI Silver 2500/40 CSR73	M KP HI Silver 250/20 CSR87	M KP HI Silver 0/10 CSR94
Plan type	**Deductible**	**Deductible**	**Copayment**
Features			
Annual medical deductible (individual/family)	$2,500/$5,000	$250/$500	None/None
Annual out-of-pocket maximum (individual/family)	$6,350/$12,700	$2,700/$5,400	$2,500/$5,000
Benefits			
Preventive care			
Routine physical exam, mammograms, etc.	No charge	No charge	No charge
Outpatient services (per visit or procedure)			
Primary care office visit	$40	$20	$10
Specialty care office visit	$60	$40	$30
Most X-rays	$40	$20	$10
Most lab tests	$40	$20	$10
MRI, CT, PET	$300 after deductible	$150	$50
Outpatient surgery	30% after deductible	20% after deductible	10% coinsurance
Mental health visit	$40	$20	$10
Inpatient hospital care			
Room and board, surgery, anesthesia, X-rays, lab tests, medications, mental health care	30% after deductible	20% after deductible	10% coinsurance
Maternity			
Routine prenatal care visit, first postpartum visit	No charge	No charge	No charge
Delivery and inpatient well-baby care	30% after deductible	20% after deductible	10% coinsurance
Emergency and urgent care			
Emergency Department visit	30% after deductible	20% after deductible	10% coinsurance
Urgent care visit	20% applicable charges/ $40 primary or $60 specialty	20% applicable charges/ $20 primary or $40 specialty	20% applicable charges/ $10 primary or $30 specialty
Prescription drugs (up to a 30-day supply)			
Generic	$20* generic/ $3* generic maintenance	$15* generic/ $3* generic maintenance	$5* generic/ $0* generic maintenance
Preferred brand	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Non-preferred brand	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Specialty	50% after $500 pharmacy deductible	40% after $100 pharmacy deductible	10% coinsurance
Whole health			
Healthy services	KP Fit Rewards**	KP Fit Rewards**	KP Fit Rewards**

* Mail order: Up to a 90-day supply of qualified prescriptions for the cost of a 60-day supply.
† After 4 days, there is no charge for covered services related to the admission.
‡ Waived if admitted
** Fit Rewards administered by American Specialty Health Fitness, Inc. Please visit **kp.org/fitrewards** for more information.

This plan summary is intended to highlight only some of the most frequently asked about benefits and their copays, coinsurance, and deductibles. Please refer to the *Kaiser Permanente Hawaii's Guide to Your Health Plan* for complete details on your plan or for specific limitations and exclusions. To request a copy of the *Kaiser Permanente Hawaii's Guide to Your Health Plan,* please visit **kp.org/plandocuments**, call us at **1-800-966-5955,** or contact your broker. For services subject to the deductible, you'll have to pay health care expenses out of pocket until you meet your deductible. Most deductibles, copays, and coinsurance contribute to the out-of-pocket maximum.

The 2020 Kaiser Permanente for Individuals and Families rates and benefits are still pending state regulatory review and may be subject to change. If rates are revised, we will send you those revised rates as soon as they are available. Benefits are for effective dates beginning January 1, 2020, and are subject to change.

Find your rate

Use the monthly rates chart on the following pages or apply on **buykp.org/apply** to have your rate calculated automatically. Along with your monthly rate, consider what you'll need to pay when you get care.

How is your rate determined?

Your rate is based on:

- The plan you choose
- Where you live, based on your ZIP code
- Your age on your plan start date (effective date)
- If you qualify for federal financial assistance. Visit **buykp.org/apply** or call us at **1-800-494-5314** to see if you may qualify.
- If you use tobacco
- If you already have pediatric dental coverage for children 18 and younger

Interested in a family plan?

Find the rate for each family member, based on his or her age on the start date.

Family members include:

- You
- Your spouse/domestic partner
- All adult children 21 through 25
- Your 3 oldest children under 21

If you have more than 3 children under 21, you only need to pay for the 3 oldest. The other children under 21 will be covered at no charge.

The rates in the monthly rates chart apply to these ZIP codes. Please check that your ZIP code is listed below. If it isn't, call us at **1-800-494-5314** for information on other rate areas.

ZIP codes			
96701	96759–96774	96828	96853–54
96703–96710	96776–96786	96830	96857–61
96712–96722	96788–96793	96836–41	96863
96725–96734	96795–96797	96843–44	96898
96737–96757	96801–96826	96846–50	

Pediatric dental care benefits

When you purchase a health plan directly from Kaiser Permanente, your plan includes Hawaii Dental Service (HDS) pediatric dental benefits for children age 18 and younger. The pediatric dental plan includes 2 free examinations, cleanings, and fluoride treatments per calendar year. Plus you'll have access to the large HDS network of dentists – 9 out of 10 of Hawaii's licensed, practicing dentists accept HDS.

If you buy your health plan through HealthCare.gov, individuals on your plan aged 18 and younger must still have pediatric dental benefits. You can purchase the same HDS pediatric dental plan on healthcare.gov by selecting the pediatric dental plan named "HDS 2990."

Pediatric dental plan features

You pay:
Examination – twice per calendar year: $0
Bitewing X-rays – twice per calendar year: 70%
Cleanings – twice per calendar year: $0
Sealants: $0
Fillings: 70%
Fluoride – twice per calendar year: $0

KAISER PERMANENTE®

2020 Monthly rates Off Exchange

Please note: These rates do not include the federal financial assistance you may be eligible to receive through the Health Insurance Marketplace.

Age on 2020 effective date	KP HI Bronze 5500/30% Off	KP HI Bronze 6500/60 Off	KP HI Silver 4000/45 Off	KP HI Silver 2500/40 Off	KP HI Gold 1000/30 Off	KP HI Gold 0/30 Off	KP HI Platinum 0/10 Off	KP HI Bronze 6500/60 Plus CAM Off	KP HI Silver 2500/40 Plus CAM Off	KP HI Gold 0/30 Plus CAM Off	KP HI Platinum 0/10 Plus CAM Off
0–14	$230.71	$220.27	$240.51	$245.83	$293.83	$309.59	$351.05	$221.93	$247.52	$311.22	$352.71
15	251.22	239.85	261.88	267.68	319.95	337.11	382.25	241.66	269.53	338.88	384.06
16	259.06	247.33	270.06	276.03	329.93	347.63	394.18	249.20	277.94	349.46	396.05
17	266.90	254.82	278.23	284.39	339.92	358.15	406.11	256.74	286.35	360.04	408.04
18	275.34	262.88	287.04	293.39	350.67	369.48	418.96	264.87	295.41	371.43	420.94
19	283.79	270.95	295.84	302.38	361.43	380.82	431.81	272.99	304.47	382.82	433.85
20	292.53	279.30	304.96	311.70	372.57	392.55	445.12	281.40	313.85	394.62	447.22
21	301.58	287.93	314.39	321.34	384.09	404.69	458.89	290.10	323.56	406.82	461.06
22	301.58	287.93	314.39	321.34	384.09	404.69	458.89	290.10	323.56	406.82	461.06
23	301.58	287.93	314.39	321.34	384.09	404.69	458.89	290.10	323.56	406.82	461.06
24	301.58	287.93	314.39	321.34	384.09	404.69	458.89	290.10	323.56	406.82	461.06
25	302.79	289.09	315.64	322.63	385.62	406.31	460.72	291.27	324.85	408.45	462.90
26	308.82	294.84	321.93	329.06	393.31	414.41	469.90	297.07	331.32	416.58	472.12
27	316.06	301.75	329.48	336.77	402.52	424.12	480.91	304.03	339.09	426.35	483.19
28	327.82	312.98	341.74	349.30	417.50	439.90	498.81	315.34	351.71	442.21	501.17
29	337.47	322.20	351.80	359.58	429.79	452.85	513.49	324.63	362.06	455.23	515.92
30	342.29	326.80	356.83	364.73	435.94	459.33	520.83	329.27	367.24	461.74	523.30
31	349.53	333.71	364.37	372.44	445.16	469.04	531.85	336.23	375.01	471.50	534.36
32	356.77	340.63	371.92	380.15	454.38	478.75	542.86	343.19	382.77	481.27	545.43
33	361.29	344.94	376.64	384.97	460.14	484.82	549.74	347.55	387.62	487.37	552.35
34	366.12	349.55	381.67	390.11	466.28	491.30	557.09	352.19	392.80	493.88	559.72
35	368.53	351.85	384.18	392.68	469.36	494.53	560.76	354.51	395.39	497.13	563.41
36	370.94	354.16	386.70	395.25	472.43	497.77	564.43	356.83	397.98	500.39	567.10
37	373.36	356.46	389.21	397.82	475.50	501.01	568.10	359.15	400.57	503.64	570.79
38	375.77	358.76	391.73	400.39	478.57	504.25	571.77	361.47	403.15	506.90	574.48
39	380.60	363.37	396.76	405.54	484.72	510.72	579.11	366.11	408.33	513.41	581.85
40	385.42	367.98	401.79	410.68	490.86	517.20	586.46	370.75	413.51	519.92	589.23
41	392.66	374.89	409.33	418.39	500.08	526.91	597.47	377.72	421.27	529.68	600.30
42	399.59	381.51	416.56	425.78	508.92	536.22	608.02	384.39	428.72	539.04	610.90
43	409.25	390.73	426.62	436.06	521.21	549.17	622.71	393.67	439.07	552.05	625.65
44	421.31	402.24	439.20	448.92	536.57	565.36	641.06	405.28	452.01	568.33	644.10
45	435.48	415.78	453.97	464.02	554.62	584.38	662.63	418.91	467.22	587.45	665.77
46	452.37	431.90	471.58	482.02	576.13	607.04	688.33	435.16	485.34	610.23	691.58
47	471.37	450.04	491.39	502.26	600.33	632.53	717.24	453.43	505.72	635.86	720.63
48	493.08	470.77	514.02	525.40	627.98	661.67	750.28	474.32	529.02	665.15	753.83
49	514.50	491.21	536.34	548.21	655.25	690.41	782.86	494.92	551.99	694.03	786.56
50	538.62	514.25	561.49	573.92	685.98	722.78	819.57	518.13	577.88	726.58	823.45
51	562.45	537.00	586.33	599.31	716.32	754.75	855.82	541.04	603.44	758.72	859.87
52	588.69	562.05	613.68	627.26	749.74	789.96	895.74	566.28	631.59	794.11	899.98
53	615.23	587.38	641.35	655.54	783.54	825.57	936.13	591.81	660.06	829.91	940.55
54	643.88	614.74	671.22	686.07	820.03	864.02	979.72	619.37	690.80	868.56	984.35
55	672.53	642.09	701.08	716.60	856.52	902.46	1,023.31	646.93	721.54	907.21	1,028.16
56	703.59	671.75	733.46	749.69	896.08	944.15	1,070.58	676.81	754.86	949.11	1,075.64
57	734.95	701.69	766.16	783.11	936.02	986.24	1,118.30	706.98	788.51	991.42	1,123.59
58	768.43	733.65	801.06	818.78	978.66	1,031.16	1,169.24	739.19	824.43	1,036.58	1,174.77
59	785.01	749.49	818.35	836.46	999.78	1,053.41	1,194.48	755.14	842.22	1,058.95	1,200.13
60	818.49	781.45	853.25	872.13	1,042.41	1,098.34	1,245.41	787.34	878.14	1,104.11	1,251.31
61	847.44	809.09	883.43	902.98	1,079.29	1,137.19	1,289.47	815.19	909.20	1,143.16	1,295.57
62	866.44	827.23	903.23	923.22	1,103.48	1,162.68	1,318.38	833.47	929.59	1,168.79	1,324.61
63	890.27	849.98	928.07	948.61	1,133.83	1,194.65	1,354.63	856.39	955.15	1,200.93	1,361.04
64+	904.74	863.79	943.16	964.02	1,152.26	1,214.07	1,376.65	870.30	970.68	1,220.46	1,383.17

Rates are effective January 1, 2020, through December 31, 2020.

Pediatric dental plan: Add the $27.08 per child age 18 and younger.

2020 Monthly rates On Exchange

Please note: These rates do not include the federal financial assistance you may be eligible to receive through the Health Insurance Marketplace.

Age on 2020 effective date	KP HI Bronze 5500/30%	KP HI Bronze 6500/60	KP HI Bronze 6500/60 Plus CAM	KP HI Silver 4000/45	KP HI Silver 2500/40	KP HI Silver 2500/40 Plus CAM	KP HI Gold 1000/30	KP HI Gold 0/30	KP HI Gold 0/30 Plus CAM	KP HI Platinum 0/10
0–14	$230.71	$220.27	$221.93	$275.62	$281.79	$283.73	$293.83	$309.59	$311.22	$351.05
15	251.22	239.85	241.66	300.12	306.84	308.95	319.95	337.11	338.88	382.25
16	259.06	247.33	249.20	309.49	316.42	318.59	329.93	347.63	349.46	394.18
17	266.90	254.82	256.74	318.86	326.00	328.23	339.92	358.15	360.04	406.11
18	275.34	262.88	264.87	328.95	336.31	338.62	350.67	369.48	371.43	418.96
19	283.79	270.95	272.99	339.04	346.62	349.00	361.43	380.82	382.82	431.81
20	292.53	279.30	281.40	349.48	357.31	359.76	372.57	392.55	394.62	445.12
21	301.58	287.93	290.10	360.29	368.36	370.88	384.09	404.69	406.82	458.89
22	301.58	287.93	290.10	360.29	368.36	370.88	384.09	404.69	406.82	458.89
23	301.58	287.93	290.10	360.29	368.36	370.88	384.09	404.69	406.82	458.89
24	301.58	287.93	290.10	360.29	368.36	370.88	384.09	404.69	406.82	458.89
25	302.79	289.09	291.27	361.73	369.83	372.37	385.62	406.31	408.45	460.72
26	308.82	294.84	297.07	368.94	377.20	379.78	393.31	414.41	416.58	469.90
27	316.06	301.75	304.03	377.59	386.04	388.69	402.52	424.12	426.35	480.91
28	327.82	312.98	315.34	391.64	400.40	403.15	417.50	439.90	442.21	498.81
29	337.47	322.20	324.63	403.17	412.19	415.02	429.79	452.85	455.23	513.49
30	342.29	326.80	329.27	408.93	418.09	420.95	435.94	459.33	461.74	520.83
31	349.53	333.71	336.23	417.58	426.93	429.85	445.16	469.04	471.50	531.85
32	356.77	340.63	343.19	426.23	435.77	438.76	454.38	478.75	481.27	542.86
33	361.29	344.94	347.55	431.63	441.29	444.32	460.14	484.82	487.37	549.74
34	366.12	349.55	352.19	437.40	447.19	450.25	466.28	491.30	493.88	557.09
35	368.53	351.85	354.51	440.28	450.13	453.22	469.36	494.53	497.13	560.76
36	370.94	354.16	356.83	443.16	453.08	456.19	472.43	497.77	500.39	564.43
37	373.36	356.46	359.15	446.04	456.03	459.15	475.50	501.01	503.64	568.10
38	375.77	358.76	361.47	448.93	458.97	462.12	478.57	504.25	506.90	571.77
39	380.60	363.37	366.11	454.69	464.87	468.05	484.72	510.72	513.41	579.11
40	385.42	367.98	370.75	460.45	470.76	473.99	490.86	517.20	519.92	586.46
41	392.66	374.89	377.72	469.10	479.60	482.89	500.08	526.91	529.68	597.47
42	399.59	381.51	384.39	477.39	488.07	491.42	508.92	536.22	539.04	608.02
43	409.25	390.73	393.67	488.92	499.86	503.29	521.21	549.17	552.05	622.71
44	421.31	402.24	405.28	503.33	514.60	518.12	536.57	565.36	568.33	641.06
45	435.48	415.78	418.91	520.26	531.91	535.56	554.62	584.38	587.45	662.63
46	452.37	431.90	435.16	540.44	552.54	556.33	576.13	607.04	610.23	688.33
47	471.37	450.04	453.43	563.14	575.74	579.69	600.33	632.53	635.86	717.24
48	493.08	470.77	474.32	589.08	602.26	606.39	627.98	661.67	665.15	750.28
49	514.50	491.21	494.92	614.66	628.42	632.73	655.25	690.41	694.03	782.86
50	538.62	514.25	518.13	643.48	657.89	662.40	685.98	722.78	726.58	819.57
51	562.45	537.00	541.04	671.95	686.99	691.70	716.32	754.75	758.72	855.82
52	588.69	562.05	566.28	703.29	719.03	723.96	749.74	789.96	794.11	895.74
53	615.23	587.38	591.81	735.00	751.45	756.60	783.54	825.57	829.91	936.13
54	643.88	614.74	619.37	769.23	786.44	791.84	820.03	864.02	868.56	979.72
55	672.53	642.09	646.93	803.45	821.44	827.07	856.52	902.46	907.21	1,023.31
56	703.59	671.75	676.81	840.56	859.38	865.27	896.08	944.15	949.11	1,070.58
57	734.95	701.69	706.98	878.03	897.69	903.84	936.02	986.24	991.42	1,118.30
58	768.43	733.65	739.19	918.03	938.58	945.01	978.66	1,031.16	1,036.58	1,169.24
59	785.01	749.49	755.14	937.84	958.83	965.41	999.78	1,053.41	1,058.95	1,194.48
60	818.49	781.45	787.34	977.83	999.72	1,006.58	1,042.41	1,098.34	1,104.11	1,245.41
61	847.44	809.09	815.19	1,012.42	1,035.08	1,042.18	1,079.29	1,137.19	1,143.16	1,289.47
62	866.44	827.23	833.47	1,035.12	1,058.29	1,065.55	1,103.48	1,162.68	1,168.79	1,318.38
63	890.27	849.98	856.39	1,063.58	1,087.39	1,094.85	1,133.83	1,194.65	1,200.93	1,354.63
64+	904.74	863.79	870.30	1,080.87	1,105.07	1,112.64	1,152.26	1,214.07	1,220.46	1,376.65

Rates are effective January 1, 2020, through December 31, 2020.
Pediatric dental plan: Add the $27.08 per child age 18 and younger.

KAISER PERMANENTE®

2020 Monthly rates On Exchange

Please note: These rates do not include the federal financial assistance you may be eligible to receive through the Health Insurance Marketplace.

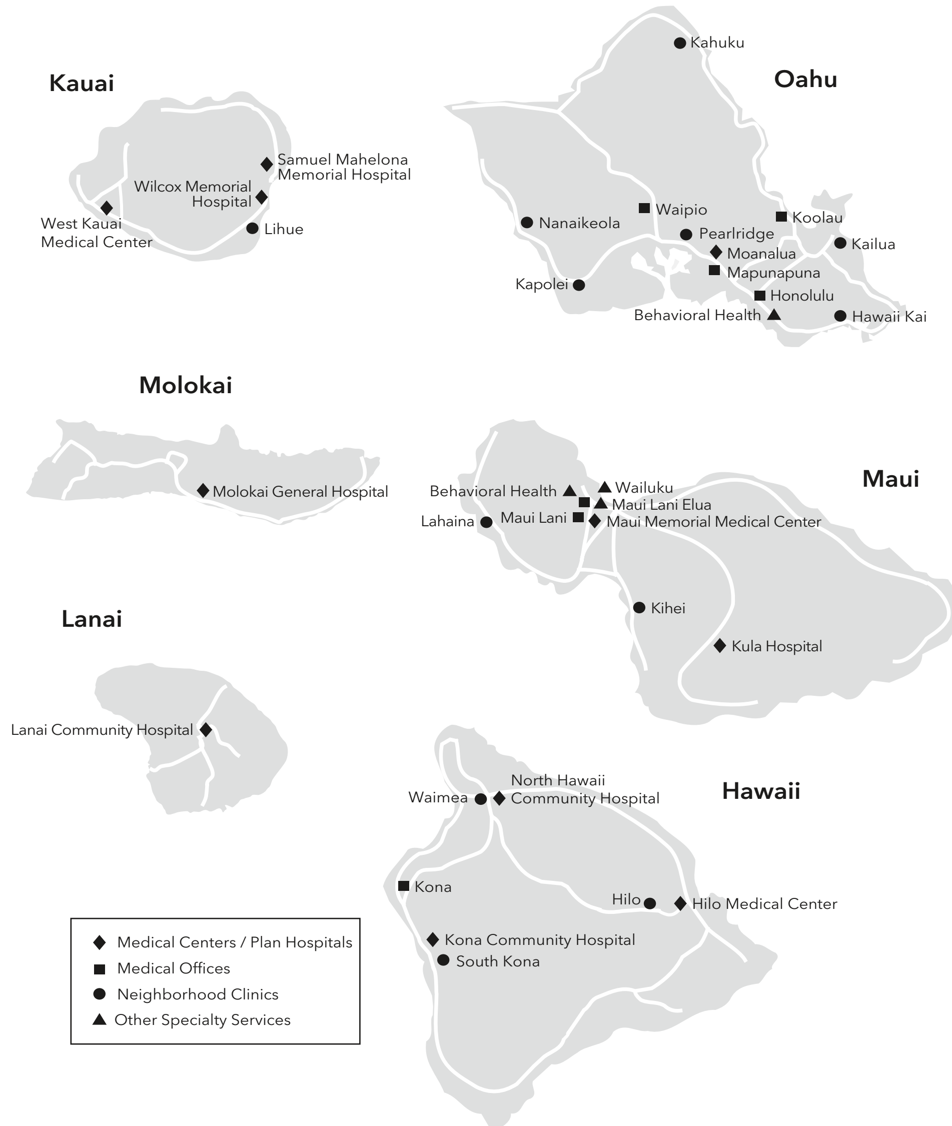
Age on 2019 effective date	KP HI Platinum 0/10 Plus CAM	KP HI Silver 3500/40 CSR73	KP HI Silver 750/10 CSR87	KP HI Silver 50/5 CSR94	KP HI Silver 2500/40 CSR73	KP HI Silver 250/20 CSR87	KP HI Silver 250/20 CSR87 Plus CAM	KP HI Silver 2500/40 CSR73 Plus CAM	KP HI Silver 0/10 CSR94	KP HI Silver 0/10 CSR94 Plus CAM
0–14	$352.71	$275.62	$275.62	$275.62	$281.79	$281.79	$283.73	$283.73	$281.79	$283.73
15	384.06	300.12	300.12	300.12	306.84	306.84	308.95	308.95	306.84	308.95
16	396.05	309.49	309.49	309.49	316.42	316.42	318.59	318.59	316.42	318.59
17	408.04	318.86	318.86	318.86	326.00	326.00	328.23	328.23	326.00	328.23
18	420.94	328.95	328.95	328.95	336.31	336.31	338.62	338.62	336.31	338.62
19	433.85	339.04	339.04	339.04	346.62	346.62	349.00	349.00	346.62	349.00
20	447.22	349.48	349.48	349.48	357.31	357.31	359.76	359.76	357.31	359.76
21	461.06	360.29	360.29	360.29	368.36	368.36	370.88	370.88	368.36	370.88
22	461.06	360.29	360.29	360.29	368.36	368.36	370.88	370.88	368.36	370.88
23	461.06	360.29	360.29	360.29	368.36	368.36	370.88	370.88	368.36	370.88
24	461.06	360.29	360.29	360.29	368.36	368.36	370.88	370.88	368.36	370.88
25	462.90	361.73	361.73	361.73	369.83	369.83	372.37	372.37	369.83	372.37
26	472.12	368.94	368.94	368.94	377.20	377.20	379.78	379.78	377.20	379.78
27	483.19	377.59	377.59	377.59	386.04	386.04	388.69	388.69	386.04	388.69
28	501.17	391.64	391.64	391.64	400.40	400.40	403.15	403.15	400.40	403.15
29	515.92	403.17	403.17	403.17	412.19	412.19	415.02	415.02	412.19	415.02
30	523.30	408.93	408.93	408.93	418.09	418.09	420.95	420.95	418.09	420.95
31	534.36	417.58	417.58	417.58	426.93	426.93	429.85	429.85	426.93	429.85
32	545.43	426.23	426.23	426.23	435.77	435.77	438.76	438.76	435.77	438.76
33	552.35	431.63	431.63	431.63	441.29	441.29	444.32	444.32	441.29	444.32
34	559.72	437.40	437.40	437.40	447.19	447.19	450.25	450.25	447.19	450.25
35	563.41	440.28	440.28	440.28	450.13	450.13	453.22	453.22	450.13	453.22
36	567.10	443.16	443.16	443.16	453.08	453.08	456.19	456.19	453.08	456.19
37	570.79	446.04	446.04	446.04	456.03	456.03	459.15	459.15	456.03	459.15
38	574.48	448.93	448.93	448.93	458.97	458.97	462.12	462.12	458.97	462.12
39	581.85	454.69	454.69	454.69	464.87	464.87	468.05	468.05	464.87	468.05
40	589.23	460.45	460.45	460.45	470.76	470.76	473.99	473.99	470.76	473.99
41	600.30	469.10	469.10	469.10	479.60	479.60	482.89	482.89	479.60	482.89
42	610.90	477.39	477.39	477.39	488.07	488.07	491.42	491.42	488.07	491.42
43	625.65	488.92	488.92	488.92	499.86	499.86	503.29	503.29	499.86	503.29
44	644.10	503.33	503.33	503.33	514.60	514.60	518.12	518.12	514.60	518.12
45	665.77	520.26	520.26	520.26	531.91	531.91	535.56	535.56	531.91	535.56
46	691.58	540.44	540.44	540.44	552.54	552.54	556.33	556.33	552.54	556.33
47	720.63	563.14	563.14	563.14	575.74	575.74	579.69	579.69	575.74	579.69
48	753.83	589.08	589.08	589.08	602.26	602.26	606.39	606.39	602.26	606.39
49	786.56	614.66	614.66	614.66	628.42	628.42	632.73	632.73	628.42	632.73
50	823.45	643.48	643.48	643.48	657.89	657.89	662.40	662.40	657.89	662.40
51	859.87	671.95	671.95	671.95	686.99	686.99	691.70	691.70	686.99	691.70
52	899.98	703.29	703.29	703.29	719.03	719.03	723.96	723.96	719.03	723.96
53	940.55	735.00	735.00	735.00	751.45	751.45	756.60	756.60	751.45	756.60
54	984.35	769.23	769.23	769.23	786.44	786.44	791.84	791.84	786.44	791.84
55	1,028.16	803.45	803.45	803.45	821.44	821.44	827.07	827.07	821.44	827.07
56	1,075.64	840.56	840.56	840.56	859.38	859.38	865.27	865.27	859.38	865.27
57	1,123.59	878.03	878.03	878.03	897.69	897.69	903.84	903.84	897.69	903.84
58	1,174.77	918.03	918.03	918.03	938.58	938.58	945.01	945.01	938.58	945.01
59	1,200.13	937.84	937.84	937.84	958.83	958.83	965.41	965.41	958.83	965.41
60	1,251.31	977.83	977.83	977.83	999.72	999.72	1,006.58	1,006.58	999.72	1,006.58
61	1,295.57	1,012.42	1,012.42	1,012.42	1,035.08	1,035.08	1,042.18	1,042.18	1,035.08	1,042.18
62	1,324.61	1,035.12	1,035.12	1,035.12	1,058.29	1,058.29	1,065.55	1,065.55	1,058.29	1,065.55
63	1,361.04	1,063.58	1,063.58	1,063.58	1,087.39	1,087.39	1,094.85	1,094.85	1,087.39	1,094.85
64+	1,383.17	1,080.87	1,080.87	1,080.87	1,105.07	1,105.07	1,112.64	1,112.64	1,105.07	1,112.64

Rates are effective January 1, 2020, through December 31, 2020.

Pediatric dental plan: Add the $27.08 per child age 18 and younger.

Find a facility near you

Our goal is to make it as easy and convenient as possible for you to get the care you need when you need it. Please refer to the map below or visit **kp.org/facilities** to find the one nearest you.



Have questions? Call us at **1-800-494-5314.** • Go to **buykp.org/apply**. • Or contact your agent or broker.

Notes

Notes

Helpful websites and phone numbers

Have questions about enrolling or getting started with Kaiser Permanente? Want to learn more about our services? Use this information to explore the resources available to members, or to get answers to any questions you have.

Kaiser Permanente

Discover Kaiser Permanente .... **kp.org/thrive**

Enrollment resources

Apply online .... **buykp.org/apply**

Get started if you're a new member .... **kp.org/newmember**

Enroll during a special enrollment period .... **kp.org/specialenrollment**

Member resources

Manage your care .... **kp.org**

Find a location near you .... **kp.org/facilities**

Choose your doctor .... **kp.org/searchdoctors**

Create your online account .... **kp.org/registernow**

Get an idea of what your care will cost .... **kp.org/treatmentestimates**

Get an estimate of what you'll pay for your care .... **kp.org/costestimates**

Get a copy of your *Kaiser Permanente Hawaii's Guide to Your Health Plan* (Guide) .... **kp.org/plandocuments**

Additional resources

Find resources for healthier living .... **kp.org/healthyliving**

Get in touch with us by phone

Get general information about Kaiser Permanente **1-800-494-5314**

The right choice for a healthier you

Having a good health plan is important. So is getting quality care.
With Kaiser Permanente, you get both.

Want to learn more?

Visit **kp.org** or call us at **1-800-494-5314** (TTY **711**).

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