



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 <https://kp.org/plandocuments> or call 1-855-249-5005 (TTY:711). 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-249-5005 (TTY:711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,500 Individual / \$9,000 Family                                                                                                     | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.                                                | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. \$50 Individual for Pediatric Dental in <a href="#">network</a> . There are no other specific <a href="#">deductibles</a> .        | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,300 Individual / \$16,600 Family                                                                                                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-855-249-5005 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers                                                              | Why this Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes, but you may self-refer to certain <a href="#">specialists</a> . | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                    | What You Will Pay Plan Provider<br>(You will pay the least)                                       | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                       |
|------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness         | \$30 / visit. 30% <a href="#">coinsurance</a> for other covered services received during a visit. | Not covered                                                    | Virtual Care Services: No charge                                                                                                                                                                                            |
|                                                                        | <a href="#">Specialist</a> visit                         | \$60 / visit. 30% <a href="#">coinsurance</a> for other covered services received during a visit. | Not covered                                                    | Virtual Care Services: No charge                                                                                                                                                                                            |
|                                                                        | <a href="#">Preventive care/ screening/ immunization</a> | No charge, <a href="#">deductible</a> does not apply                                              | Not covered                                                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)      | 30% <a href="#">coinsurance</a>                                                                   | Not covered                                                    | None                                                                                                                                                                                                                        |
|                                                                        | Imaging (CT/PET scans, MRI's)                            | 30% <a href="#">coinsurance</a>                                                                   | Not covered                                                    | None                                                                                                                                                                                                                        |

| Common Medical Event                                                                                                                                                                                                                             | Services You May Need                            | What You Will Pay Plan Provider<br>(You will pay the least)                                                          | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.kp.org/formulary">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">http://www.kp.org/formulary</a> | Generic drugs                                    | \$10 retail and \$20 mail order / <a href="#">prescription</a> .                                                     | Not covered                                                    | Up to a 30-day supply (retail); up to a 90-day supply (mail order). <a href="#">Prescription</a> refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to <a href="#">formulary</a> guidelines. <a href="#">Formulary preventive</a> and contraceptive drugs in all tiers are no charge, <a href="#">deductible</a> does not apply. |
|                                                                                                                                                                                                                                                  | Preferred brand drugs                            | \$45 retail and \$90 mail order / <a href="#">prescription</a> .                                                     | Not covered                                                    | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                  | Non-preferred drugs                              | 30% <a href="#">coinsurance</a> retail and mail order                                                                | Not covered                                                    | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                  | <a href="#">Specialty drugs</a>                  | 30% <a href="#">coinsurance</a> retail                                                                               | Not covered                                                    | Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.                                                                                                                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                            | Facility fee (e.g., ambulatory surgery center)   | Ambulatory surgical center: 20% <a href="#">coinsurance</a> . Outpatient hospital: 30% <a href="#">coinsurance</a> . | Not covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                  | Physician/surgeon fees                           | Ambulatory surgical center: 20% <a href="#">coinsurance</a> . Outpatient hospital: 30% <a href="#">coinsurance</a> . | Not covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                   | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>                                                                                      | 30% <a href="#">coinsurance</a>                                | None                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                  | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>                                                                                      | 30% <a href="#">coinsurance</a>                                | None                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                  | <a href="#">Urgent care</a>                      | \$100 / visit                                                                                                        | \$100 / visit                                                  | <a href="#">Non-Plan Providers</a> are not covered when inside the service area.                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay Plan Provider<br>(You will pay the least)                                | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                  |
|----------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |
|                                                                                  | Physician/surgeon fee                     | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$30 / individual visit                                                                    | Not covered                                                    | \$15 / group visit. Annual Wellness Visit: No charge, <a href="#">deductible</a> does not apply and Virtual Care Services: No charge.                                                                                                  |
|                                                                                  | Inpatient services                        | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |
| <b>If you are pregnant</b>                                                       | Office visits                             | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                  |
|                                                                                  | Childbirth/delivery professional services | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |
|                                                                                  | Childbirth/delivery facility services     | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | Less than 8 hours / day and 28 hours / week.                                                                                                                                                                                           |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Outpatient services: \$30 / visit.<br>Inpatient service: 30% <a href="#">coinsurance</a> . | Not covered                                                    | Outpatient: 20 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge, <a href="#">deductible</a> does not apply. Inpatient: Limited to 60 days / condition / year. |
|                                                                                  | <a href="#">Habilitation services</a>     | Outpatient services: \$30 / visit                                                          | Not covered                                                    | 20 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge.                                                                                                          |
|                                                                                  | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | 100-day limit / year.                                                                                                                                                                                                                  |
|                                                                                  | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                                       |
|                                                                                  | <a href="#">Hospice service</a>           | 30% <a href="#">coinsurance</a>                                                            | Not covered                                                    | None                                                                                                                                                                                                                                   |

| Common Medical Event                   | Services You May Need      | What You Will Pay Plan Provider (You will pay the least)                                                                                                                                                                               | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                              |
|----------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If your child needs dental or eye care | Children's eye exam        | \$30 / visit. 30% <a href="#">coinsurance</a> for other covered services received during a visit.                                                                                                                                      | Not covered                                                 | Limited to members up to the end of the year in which the member turns 19.                                                                                                                                         |
|                                        | Children's glasses         | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                        | Not covered                                                 | Limited to members up to the end of the year in which the member turns 19. One pair of frames and lenses or contact lenses / 24 months.                                                                            |
|                                        | Children's dental check-up | No charge for <a href="#">preventive care</a> / diagnostic services after pediatric dental <a href="#">deductible</a> . 50% <a href="#">coinsurance</a> for basic / major services after pediatric dental <a href="#">deductible</a> . | Not covered                                                 | Limited to members up to the end of the month in which the member turns 19; limited coverage for diagnostic and <a href="#">preventive services</a> , minor restorative (fillings), simple extractions and crowns. |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)  |                                                                                                                                                                                      |                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Cosmetic surgery</li> <li>Hearing aids (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>                                                         | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>                                                   |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                       |                                                                                                                                                                                      |                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Acupuncture (10 visit limit/year)</li> <li>Bariatric surgery</li> </ul>                                                                                     | <ul style="list-style-type: none"> <li>Chiropractic care (20 visit limit/year)</li> <li>Dental care (Adult)</li> <li>Hearing aids (Up to age 18: 1 aid / ear / 60 months)</li> </ul> | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Private-duty nursing (Inpatient)</li> <li>Routine eye care (Adult)</li> </ul> |

**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](http://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 on how 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 Appeals Rights:

|                                   |                                                                                                       |
|-----------------------------------|-------------------------------------------------------------------------------------------------------|
| Kaiser Permanente Member Services | 1-855-249-5005 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a> |
|-----------------------------------|-------------------------------------------------------------------------------------------------------|

|                                                                                              |                                                                                                                               |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>                     |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                                             |
| Colorado Division of Insurance                                                               | 303-894-7490 (instate, toll-free: 800-930-3745) or <a href="mailto:insurance@dora.state.co.us">insurance@dora.state.co.us</a> |

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5005 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-855-249-5005 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5005 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5005 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-855-249-5005 (TTY: 711)

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$4,500         |
| <a href="#">Copayments</a>             | \$10            |
| <a href="#">Coinsurance</a>            | \$2,300         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$6,870</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$2,200        |
| <a href="#">Copayments</a>             | \$1,300        |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$3,500</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$2,800        |
| <a href="#">Copayments</a>             | \$0            |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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### Colorado Supplement to the Summary of Benefits and Coverage Form

|                                                      |                                                                                                                                                                                     |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>INSURANCE COMPANY NAME</b>                        | Kaiser Foundation Health Plan of Colorado                                                                                                                                           |
| <b>NAME OF PLAN</b>                                  | KP Select CO Silver 4500/30/ HSA                                                                                                                                                    |
| <b>1. Type of Policy</b>                             | Small Employer Group Policy                                                                                                                                                         |
| <b>2. Type of plan</b>                               | Health maintenance organization (HMO)                                                                                                                                               |
| <b>3. Areas of Colorado where plan is available.</b> | Plan is available <b>only</b> in the following counties:<br>Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park and Teller |

#### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

**Important Note:** The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

**INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.**

This means if you live or work outside of the service area where this plan is available, you will have to travel into this service area to receive non-emergency or non-urgent covered services.

|                                  | Description                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>4. Annual Deductible Type</b> | <p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</p>                           |
| <b>5. Out-of-Pocket Maximum</b>  | <p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p> |

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>6. What is included in the In-Network Out-of-Pocket Maximum?</b> | Deductibles, coinsurance and copayments.<br>As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement. |
| <b>7. Is pediatric dental covered by this plan?</b>                 | Yes, pediatric dental is subject to a separate \$50 deductible.                                                                                                                                                                                                                                                                                                                                                                              |
| <b>8. What cancer screenings are covered?</b>                       | Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))                                                                                        |

#### USING THE PLAN

|                                                                                                                                         | IN-NETWORK | OUT-OF-NETWORK                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b> | No         | Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility. |
| <b>10. Does the plan have a binding arbitration clause?</b>                                                                             | No         |                                                                                                                                                                                                   |

**Questions:** Call **1-855-249-5005** (TTY **711**) or visit us at [www.kp.org](http://www.kp.org).

SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance  
Consumer Services, Life and Health Section  
1560 Broadway, Suite 850, Denver, CO 80202  
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)  
Email: [dora\\_insurance@state.co.us](mailto:dora_insurance@state.co.us)

# NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary 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, braille, and accessible electronic formats
- Provides no-cost 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 **1-800-632-9700** (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, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

This notice is available at <https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

**አማርኛ (Amharic) ትኩረት:** አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY 711)።

**العربية (Arabic) تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700 (TTY 711)**.

**Bàsɔ̀ Wùdù (Bassa) Mbi sog:** nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsonj ni sonj, niŋ ma kénŋen yé, mbi èyem. Wò nàŋ **1-800-632-9700 (TTY 711)**

**中文 (Chinese) 注意事項:** 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700 (TTY 711)**。

**فارسی (Farsi) توجه:** اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** تماس بگیرید (TTY (تلفن متنی): **711**).

**Français (French) ATTENTION:** si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700 (TTY 711)**.

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY 711).

**Igbo (Igbo) TINYE UCHE:** Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-632-9700 (TTY 711)**.

**日本語 (Japanese) 注意:** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700**로 전화해 주세요 (TTY **711**).

**Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN:** Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódílnih **1-800-632-9700 (TTY 711)**.

**नेपाली (Nepali) ध्यान दिनुहोस्:** यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700 (TTY: 711)**.

**Afaan Oromoo (Oromo) XIYEEFFANNOO:** Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

**Русский (Russian) ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700 (TTY 711)**.

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700 (TTY 711)**.

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700 (TTY 711)**.

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700 (TTY 711)**.

**Yorùbá (Yoruba) ÀKÍYÈSÍ:** Tí o bá ń sọ èdè Yorùbá, àwọn isẹ̀ ìrànlọ́wọ́ èdè tó fí kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn isẹ̀ láísí ìdíyelé wà fún ọ. Pe **1-800-632-9700 (TTY 711)**.

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