



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see [www.kp.org/plandocuments](http://www.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> ?                                | \$1,000 Individual / \$2,000 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?              | No.                                                                                                                                  | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,000 Individual / \$8,000 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="#">Plan 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 <a href="#">plan's 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 <a href="#">provider's</a> 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. |
| 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                                                                                                                |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                          |                                                        | Plan Provider<br>(You will pay the least)                                                                                        | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                   | Primary care visit to treat an injury or illness       | \$25 / visit, <a href="#">deductible</a> does not apply.                                                                         | Not covered                                  | None                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                       | \$40 / visit, <a href="#">deductible</a> does not apply.                                                                         | Not covered                                  | None                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                          | <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)    | X-ray: 20% <a href="#">coinsurance</a><br>Lab tests: 20% <a href="#">coinsurance</a>                                             | Not covered                                  | None                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>                                                                                                  | Not covered                                  | None                                                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs                                          | \$10 (retail); \$20 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                     | Not covered                                  | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. <a href="#">Formulary preventive</a> drugs and contraceptives, in all tiers, are no charge, <a href="#">deductible</a> does not apply. |
|                                                                                                                                                                                                          | Preferred brand drugs                                  | \$30 (retail); \$60 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                     | 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                                    | \$60 (retail); \$120 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                    | Not covered                                  | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                        |
|                                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                        | 20% <a href="#">coinsurance</a> up to \$150 (retail) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply. | Not covered                                  | Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                            |
| If you have outpatient surgery                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a>                                                                                                  | Not covered                                  | None                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                          | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a>                                                                                                  | Not covered                                  | None                                                                                                                                                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                  |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Plan Provider<br>(You will pay the least)                                                                          | Non-Plan Provider<br>(You will pay the most)              |                                                                                                                                                                                       |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 / visit, <a href="#">deductible</a> does not apply.                                                          | \$150 / visit, <a href="#">deductible</a> does not apply. | <a href="#">Copayment</a> waived if admitted directly to the hospital as an inpatient.                                                                                                |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                    | 20% <a href="#">coinsurance</a>                           | None                                                                                                                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 / visit, <a href="#">deductible</a> does not apply.                                                           | Not covered                                               | <a href="#">Non-Plan Providers</a> covered when temporarily outside the service area: \$40 / visit, <a href="#">deductible</a> does not apply.                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$25 / individual visit, <a href="#">deductible</a> does not apply.                                                | Not covered                                               | \$12 / group visit, <a href="#">deductible</a> does not apply. Annual Wellness Visit: No charge, <a href="#">deductible</a> does not apply.                                           |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | Limited to less than 8 hours / day and 28 hours / week, 100 visit limit / year.                                                                                                       |
|                                                                           | <a href="#">Rehabilitation services</a>          | Outpatient: \$25 / visit, <a href="#">deductible</a> does not apply.<br>Inpatient: 20% <a href="#">coinsurance</a> | Not covered                                               | Outpatient: 60 visit limit / therapy / year.<br>Inpatient: Multi-disciplinary facility limited to 60-days / condition / year.                                                         |
|                                                                           | <a href="#">Habilitation services</a>            | \$25 / visit, <a href="#">deductible</a> does not apply.                                                           | Not covered                                               | 60 visit limit / therapy / year.                                                                                                                                                      |
|                                                                           | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | 100-day limit / year.                                                                                                                                                                 |
|                                                                           | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | Subject to <a href="#">formulary</a> guidelines.                                                                                                                                      |
|                                                                           | <a href="#">Hospice services</a>                 | 20% <a href="#">coinsurance</a>                                                                                    | Not covered                                               | None                                                                                                                                                                                  |

| Common Medical Event                          | Services You May Need      | What You Will Pay                                                            |                                              | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------|----------------------------|------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------|
|                                               |                            | Plan Provider<br>(You will pay the least)                                    | Non-Plan Provider<br>(You will pay the most) |                                                        |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | \$25 / visit for refractive exam, <a href="#">deductible</a> does not apply. | Not covered                                  | None                                                   |
|                                               | Children's glasses         | Not covered                                                                  | Not covered                                  | None                                                   |
|                                               | Children's dental check-up | Not covered                                                                  | Not covered                                  | None                                                   |

#### Excluded Services & Other Covered Services:

|                                                                                                                                                                                                         |                                                        |                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------|--|
| <b>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>.)</b> |                                                        |                                    |  |
| • Acupuncture                                                                                                                                                                                           | • Dental care (Adult and child)                        | • Routine foot care                |  |
| • Children's glasses                                                                                                                                                                                    | • Long-term care                                       | • Weight loss programs             |  |
| • Cosmetic surgery                                                                                                                                                                                      | • Non-emergency care when traveling outside the U.S.   |                                    |  |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>                                                     |                                                        |                                    |  |
| • Bariatric surgery                                                                                                                                                                                     | • Hearing aids (Up to age 18: 1 aid / ear / 60 months) | • Private-duty nursing (Inpatient) |  |
| • Chiropractic care (30 visit limit / year)                                                                                                                                                             | • Infertility treatment                                | • Routine eye care (Adult)         |  |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](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                                                               | 1-303-894-7490 (instate, toll-free: 1-800-930-3745) 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).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-249-5005 (TTY: 711).

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-855-249-5005 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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, å'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> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 20%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$10    |
| <a href="#">Coinsurance</a> | \$2,300 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$3,370</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> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 20%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

*Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$60  |
| <a href="#">Copayments</a>  | \$500 |
| <a href="#">Coinsurance</a> | \$200 |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Joe would pay is</b> | <b>\$760</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> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other (x-ray) <a href="#">coinsurance</a>                     | 20%     |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$300   |
| <a href="#">Coinsurance</a> | \$100   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |
|-----------------------------------|----------------|

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

## 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>                                  | <b>SAKS Fifth Ave CO Platinum DHMO</b>                                                                                                                                                                                                                                           |
| <b>1. Type of Policy</b>                             | Large Employer Group Policy                                                                                                                                                                                                                                                      |
| <b>2. Type of plan</b>                               | Health Maintenance Organization (HMO)                                                                                                                                                                                                                                            |
| <b>3. Areas of Colorado where plan is available.</b> | <p>Plan is available <b>only</b> in the following counties:</p> <p>Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld</p> <p><b>KP Select Plan:</b> El Paso and Teller</p> |

### 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.

|                                                                     | 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> | <p>Deductibles, coinsurance and copayments.</p> <p>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.</p> |
| <b>7. Is pediatric dental covered by this plan?</b>                 | No, the plan does not include pediatric dental.                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                               |                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>8. What cancer screenings are covered?</b> | Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer);<br>Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy);<br>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>

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## 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**).

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**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**).

**፳፻፲፱ Wūdū (Bassa) Mbi sog:** nia maa Bāsàa, njàl mbom a ka maa njàng ndol ni mbom mi tson ni son, 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** (TTY (تلفن متنی) **711**) تماس بگیرید.

**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, dị nye gị. Kpọọ **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 yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **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) XIYYEEFFANNOO:** 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 iṣẹ̀ ìrànlọ́wọ́ èdè tó fí kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn iṣẹ̀ láìsí ìdíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).