**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/ or call 1-855-249-5005 (TTY: 711) to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,000 Individual / $2,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and services indicated in chart starting on page 2. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Pediatric Dental: $50 Individual in network. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $3,250 Individual / $6,500 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums and health care this plan doesn't cover, and services indicated in chart beginning on page 2. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes, but you may self-refer to certain specialists. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 (You will pay the least) | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 / visit, deductible does not apply | Not covered | Virtual Care Services: No charge, deductible does not apply |
| | Specialist visit | $45 / visit, deductible does not apply; 25% coinsurance for other covered services received during a visit. | Not covered | Virtual Care Services: No charge, deductible does not apply |
| | Preventive care/ screening/ immunization | No charge, deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 25% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRI's) | 25% coinsurance | 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 you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.kp.org/formulary | Generic drugs | $15 / prescription (retail), deductible does not apply; $30 / prescription (mail-order), deductible does not apply | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of on-going maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive drugs and contraceptives in all tiers are no charge, deductible does not apply. |
| | Preferred brand drugs | $50 / prescription (retail), deductible does not apply; $100 / prescription (mail-order), deductible does not apply | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Non-preferred brand drugs | 25% coinsurance, deductible does not apply | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines when approved through the exception process. |
| | Specialty drugs | 25% coinsurance, deductible does not apply | Not covered | Up to a 30-day supply (retail); Subject to formulary guidelines when approved through the exception process. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgical center: 15% coinsurance; Outpatient hospital: 25% coinsurance | Not covered | None |
| | Physician/surgeon fees | Ambulatory surgical center: 15% coinsurance; Outpatient hospital: 25% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance | 25% coinsurance | None |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | None |
| | Urgent care | $75 / visit, deductible does not apply | $75 / visit, deductible does not apply | Non-plan providers are not covered inside the service area. |

| 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 you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | Not covered | None |
| | Physician/surgeon fee | 25% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 / individual visit, deductible does not apply; $10 / group visit, deductible does not apply. | Not covered | Annual Wellness Visit and Virtual Care Services: No charge, deductible does not apply |
| | Inpatient services | 25% coinsurance | Not covered | None |
| **If you are pregnant** | Office visits | 25% coinsurance | Not covered | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 25% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 25% coinsurance | 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 you need help recovering or have other special health needs** | Home health care | 25% coinsurance | Not covered | Less than 8 hours / day and 28 hours / week. |
| | Rehabilitation services | Outpatient: $20 / visit, deductible does not apply; Inpatient: 25% coinsurance | Not covered | Outpatient: 20-visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Autism spectrum disorders: $20 / visit, deductible does not apply. Virtual Care Services: No charge, deductible does not apply; Inpatient: 60-day limit / condition / year |
| | Habilitation services | $20 / visit, deductible does not apply | Not covered | 20-visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Autism spectrum disorders: $20 / visit, deductible does not apply. Virtual Care Services: No charge, deductible does not apply. |
| | Skilled nursing care | 25% coinsurance | Not covered | 100-day limit / year |
| | Durable medical equipment | 25% coinsurance | Not covered | Subject to formulary guidelines. |
| | Hospice service | No charge, deductible does not apply | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $20 / visit, deductible does not apply | Not covered | Limited to members up to the end of the year the member turns 19. |
| | Children's glasses | 50% coinsurance, deductible does not apply | 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 preventive care / diagnostic services after pediatric dental deductible. 50% coinsurance for basic/major services after pediatric dental deductible. | Not covered | Limited to members up to the end of the month the member turns 19; limited coverage for diagnostic and preventive services, minor restorative (fillings), simple extractions and crowns. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion
- Acupuncture (6-visit limit / year)
- Bariatric Surgery
- Chiropractic Care (20-visit limit / year)
- Hearing Aids (Up to age 18: 1 aid / ear / 60 months)
- Infertility Treatment
- Private-Duty Nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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 agency 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 www.kp.org/memberservices |
| Colorado Division of Insurance | 1-303-894-7490 in state, or 1-800-930-3745 out of state or www.colorado.gov/pacific/dora/division-insurance |

## 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? Not Applicable.

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

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 plan's overall deductible | $1,000 |
| Specialist cost sharing | $45 + 25% |
| Hospital (facility) coinsurance | 25% |
| Other (blood work) coinsurance | 25% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $0 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,360** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist cost sharing | $45 + 25% |
| Hospital (facility) coinsurance | 25% |
| Other (blood work) coinsurance | 25% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $60 |
| Copayments | $1,000 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,260** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist cost sharing | $45 + 25% |
| Hospital (facility) coinsurance | 25% |
| Other (x-ray) coinsurance | 25% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,500** |

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

# 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**.

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**).

**Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog:** nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, mbi èyɛm. Wɔ 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 Sprachassistenz 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 kwesịrị 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'dęę', biniit'aa da beeso ndinish'aah t'aala'í bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

**नेपाली (Nepali) ध्यान दिनुहोस्:** यदि तपाइँ नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, नि:शुल्क 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 iṣẹ́ ìrànlọ́wọ́ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

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