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 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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250 Individual / $500 Family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive services, certain services with copays, prescription drugs and hospice.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000 Individual / $6,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-855-249-5005 (TTY: 711) for a list of plan providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, but you may self-refer to certain specialist.</td>
<td>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.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
If you visit a health care provider's office or clinic

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Plan Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider's office</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Office visit: $20 <strong>Copay</strong> per visit; Phone visit: No Charge; Chat/Online visit: No Charge; Video visit: No Charge.</td>
<td>Copay not subject to deductible.</td>
</tr>
<tr>
<td>or clinic</td>
<td><strong>Specialist</strong> visit</td>
<td><strong>List item</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>X-ray: No Charge; Lab: No Charge</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 <strong>Copay</strong></td>
<td></td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-855-249-5005 or TTY 711.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider (You will pay the least)</td>
<td>Non-Plan Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail: $15 Copay; Mail Order: $30 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail: $30 Copay; Mail Order: $60 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred drugs</td>
<td>Retail: $50 Copay; Mail Order: $100 Copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% Coinsurance up to $150 per drug dispensed retail</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Ambulatory surgical center: $500 Copay; Outpatient hospital: 20% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Ambulatory surgical center: $500 Copay; Outpatient hospital: 20% Coinsurance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-855-249-5005 or TTY 711.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency room care
- **Plan Provider** (You will pay the least): $250 Copay per visit
- **Non-Plan Provider** (You will pay the most): $250 Copay per visit

Emergency room copay and imaging (CT/PET scans, MRI) copay waived if admitted directly to the hospital as an inpatient. Copay not subject to deductible.

### Emergency medical transportation
- **Plan Provider** (You will pay the least): 20% Coinsurance up to $500
- **Non-Plan Provider** (You will pay the most): 20% Coinsurance up to $500

Not subject to deductible.

### Urgent care
- **Plan Provider** (You will pay the least): $40 Copay per visit
- **Non-Plan Provider** (You will pay the most): $40 Copay per visit

Non-Plan Providers: only covered if you are out of the service area. Copay not subject to deductible.

### Facility fee (e.g., hospital room)
- **Plan Provider** (You will pay the least): 20% Coinsurance
- **Non-Plan Provider** (You will pay the most): Not Covered

None

### Physician/surgeon fees
- **Plan Provider** (You will pay the least): 20% Coinsurance
- **Non-Plan Provider** (You will pay the most): Not Covered

None

### Outpatient services
- **Plan Provider** (You will pay the least): Office visit: $20 Copay per visit; Phone visit: No Charge; Chat/Online visit: No Charge; Video visit: No Charge.
- **Non-Plan Provider** (You will pay the most): Not Covered

Group visit 50% of individual visit copay. Copay not subject to deductible.

### Inpatient services
- **Plan Provider** (You will pay the least): 20% Coinsurance
- **Non-Plan Provider** (You will pay the most): Not Covered

None

### Office visits
- **Plan Provider** (You will pay the least): 20% Coinsurance
- **Non-Plan Provider** (You will pay the most): Not Covered

After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

### Childbirth/delivery professional services
- **Plan Provider** (You will pay the least): Included in Facility fee
- **Non-Plan Provider** (You will pay the most): Not Covered

None

### Childbirth/delivery facility services
- **Plan Provider** (You will pay the least): 20% Coinsurance
- **Non-Plan Provider** (You will pay the most): Not Covered

None

For more information about limitations and exceptions, see the plan or policy document at [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-855-249-5005 or TTY 711.
### Common Medical Event

#### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Plan Provider (You will pay the least)</th>
<th>Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
<td>Limited to less than 8 hours per day and 28 hours per week.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Inpatient services: 20% Coinsurance; Outpatient services: $20 Copay per visit</td>
<td>Not Covered</td>
<td>Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Limited to 20 visits per therapy per year (Rehabilitation services for autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$20 Copay per visit</td>
<td>Not Covered</td>
<td>Outpatient: Limited to 20 visits per therapy per year (Habilitation services for autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
<td>Limited to 100 days per year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>Not Covered</td>
<td>Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance. Not subject to deductible.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Not subject to deductible.</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>$20 Copay per visit</td>
<td>For services with an ophthalmologist see &quot;Specialist visit&quot;. Copay not subject to deductible.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

#### 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
- Hearing Aids with limits (Adults)
- Long Term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Routine Dental Services
- 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.**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids with limits
- Infertility Treatment
- Private-Duty Nursing
- Routine Eye Care

For more information about limitations and exceptions, see the plan or policy document at www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711.
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 agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Member Services</td>
<td>1-855-249-5005 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a></td>
<td></td>
</tr>
<tr>
<td>Department of Labor's Employee Benefits Security Administration</td>
<td>1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Human Services, Center for Consumer Information &amp; Insurance Oversight</td>
<td>1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a></td>
<td></td>
</tr>
<tr>
<td>Colorado Division of Insurance</td>
<td>303-894-7490 (instate, toll-free: 800-930-3745) or <a href="mailto:insurance@dora.state.co.us">insurance@dora.state.co.us</a></td>
<td></td>
</tr>
</tbody>
</table>

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).]
[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).]
[Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiiijigo holne’ 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.

For more information about limitations and exceptions, see the plan or policy document at www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711.
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: $250
- Specialist copay: $40
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 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)

Total Example Cost: $12,700

In this example, Peg would pay:  
- Deductibles: $250  
- Copayments: $10  
- Coinsurance: $2,200
- What isn't covered: $60
- The total Peg would pay is: $2,520

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

- The plan's overall deductible: $250
- Specialist copay: $40
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 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)

Total Example Cost: $5,600

In this example, Joe would pay:  
- Deductibles: $0  
- Copayments: $500  
- Coinsurance: $200
- What isn't covered: $0
- The total Joe would pay is: $700

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

- The plan's overall deductible: $250
- Specialist copay: $40
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 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)

Total Example Cost: $2,800

In this example, Mia would pay:  
- Deductibles: $250  
- Copayments: $400  
- Coinsurance: $200
- What isn't covered: $0
- The total Mia would pay is: $850

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

SBC # 65850
NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

• Provide no cost 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, and accessible electronic formats

• Provide 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, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.


HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ለተፈጠረው ይተጠቀመውን ይታወቀ ከምርሽት ከርምር ፍርድ ከርምር ከተፈጠረው ይታወቀ መርጥ ለተፈጠረው ይታወቀ: ከወደ ለተፈጠረው ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወቀ ይታወKeyEvent.assertKeycode(632, 192, 192); التطبيق_الى_الجهاز(activity) :ARDS (TTX: 711)

العربية (Arabic) ملحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-800-632-9700 (TTY: 711).

Ɓǎ sɔ́ ɔ̀  Wù ɖù  (Bassa) Dè ᵇɛɛ k yɛ́ ɗɛ́ ñɛ́ ɗ ɓɛ́ì m Ɓǎ sɔ́ ɔ̀  Wù ɖù  (TTX: 711)
中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-632-9700（TTY：711）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌شود. با تماس بگیرید: 1-800-632-9700 (TTY: 711).

Français (French) ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-632-9700 (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-632-9700 (TTY: 711).

Igbo (Igbo) NRUBAMA: O buru na i na asụ Igbo, ọrụ enyemaka asusu, n’efu, diịrị gi. Kpuọ 1-800-632-9700 (TTY: 711).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-632-9700（TTY：711）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-632-9700 (TTY: 711) 번으로 전화해 주십시오.


नेपाली (Nepali) ध्वनि दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भनेत तपाईंको लिन्च्चिल्लो भाषासहयोग सेवाहुनौि निश्चित रूपमा उपलब्ध छ। 1-800-632-9700 (TTY: 711) फोल्ग गर्नुहोस्।

Afaan Oromoo (Oromo) XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiilihaa ala, ni argama. Bilbila 1-800-632-9700 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-632-9700 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-632-9700 (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-632-9700 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-632-9700 (TTY: 711).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-632-9700 (TTY: 711).
**Colorado Supplement to the Summary of Benefits and Coverage Form**

<table>
<thead>
<tr>
<th><strong>INSURANCE COMPANY NAME</strong></th>
<th>Kaiser Foundation Health Plan of Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME OF PLAN</strong></td>
<td>Colorado Community College Systems DHMO 250 20%</td>
</tr>
</tbody>
</table>

1. **Type of Policy**
   - Large Employer Group Policy

2. **Type of plan**
   - Health maintenance organization (HMO)

3. **Areas of Colorado where plan is available.**
   - Plan is available only in the following counties as determined by zip code:
     - **KP Select Plan**: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo 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.

<table>
<thead>
<tr>
<th><strong>4. Annual Deductible Type</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>EMBEDDED DEDUCTIBLE</td>
<td></td>
</tr>
<tr>
<td><strong>INDIVIDUAL</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td><strong>FAMILY</strong> – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. Out-of-Pocket Maximum</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>EMBEDDED OUT-OF-POCKET</td>
<td></td>
</tr>
<tr>
<td><strong>INDIVIDUAL</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td><strong>FAMILY</strong> – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. What is included in the In-Network Out-of-Pocket</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles, coinsurance and copayments.</td>
<td></td>
</tr>
</tbody>
</table>
## Maximum?

### 7. Is pediatric dental covered by this plan?

|  | No, the plan does not cover pediatric dental. |

### 8. What cancer screenings are covered?

|  | Breast Cancer (clinical breast exam, mammogram, 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

### 9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?

<table>
<thead>
<tr>
<th></th>
<th><strong>IN-NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>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.</td>
</tr>
</tbody>
</table>

### 10. Does the plan have a binding arbitration clause?

|  | 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 o 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