



*Kaiser Foundation Health Plan (KFHP) of Colorado, Inc., underwrites the HMO In-Network Provider Tier and Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. underwrites the Out-of-Network coverage consisting of the Non-Participating Provider Tier.

 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 or 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 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Plan Provider: \$500 Individual / \$1,500 Family; PAR Provider: \$500 Individual / \$1,500 Family; Non-PAR Provider: \$2,000 Individual / \$6,000 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 services , certain services with copays, prescription drugs and hospice.	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?	No.	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.
What is the out-of-pocket limit for this plan ?	Plan Provider: \$2,000 Individual / \$6,000 Family; PAR Provider: \$2,000 Individual / \$6,000 Family; Non-PAR Provider: \$8,000 Individual / \$24,000 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, balanced-billed charges and health care this plan doesn't cover.	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 or TTY 711 for a list of plan 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 ?	No.	You can see the specialist you choose without a referral .

 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 (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office visit: \$20 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: No Charge; Chat/Online visit: No Charge; Video visit: No Charge	Office visit: \$20 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: \$20 Copay per visit; Chat/Online visit: \$20 Copay per visit; Video visit: \$20 Copay per visit	Office visit: 40% Coinsurance Phone visit: 40% Coinsurance; Chat/Online visit: 40% Coinsurance; Video visit: 40% Coinsurance	Copay not subject to the deductible .
	Specialist visit	Office visit: \$40 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: No Charge; Chat/Online visit: No Charge; Video visit: No Charge	Office visit: \$40 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: \$40 Copay per visit; Chat/Online visit: \$40 Copay per visit; Video visit: \$40 Copay per visit	Office visit: 40% Coinsurance Phone visit: 40% Coinsurance; Chat/Online visit: 40% Coinsurance; Video visit: 40% Coinsurance	Copay not subject to the deductible .
	Preventive care/screening/im munization	No Charge	No Charge	\$70 Copay per visit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Plan and PAR provider: not subject to the deductible . Non-PAR: Copay not subject to the deductible .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: No Charge	During office: No Charge Freestanding clinic and outpatient department of a hospital: 20% Coinsurance	40% Coinsurance	Plan Provider: Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; 20% Coinsurance in the outpatient department of a hospital. PAR Provider: Diagnostic lab and x-ray services not subject to the deductible when provided during an office visit.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$15 Copay; Mail Order: \$30 Copay	Retail: \$20 Copay; Mail Order: \$40 Copay	Retail: \$20 Copay; Mail Order: Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Plan provider: Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. PAR Provider: Federally mandated over the counter items are covered with a prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). PAR Provider and Non-PAR Provider: Certain outpatient prescription drugs are subject to utilization management requirements.
	Preferred brand drugs	Retail: \$30 Copay; Mail Order: \$60 Copay	Retail: \$35 Copay; Mail Order: \$70 Copay	Retail: \$35 Copay; Mail Order: Not Covered	
	Non-preferred brand drugs	50% Coinsurance retail and mail order prescriptions	50% Coinsurance retail and mail order prescriptions	Retail: 50% Coinsurance; Mail Order: Not Covered	
	Specialty drugs	20% Coinsurance up to \$250 per drug dispensed retail and mail order prescriptions	20% Coinsurance up to \$250 per drug dispensed retail and mail order prescriptions	Retail: 20% Coinsurance up to \$250 per drug dispensed retail; Mail Order: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% coinsurance up to \$500	20% coinsurance up to \$500	20% coinsurance up to \$500	Not subject to the deductible .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
	Urgent care	\$40 Copay per visit; 20% Coinsurance for covered services received during a visit.	\$40 Copay per visit; 20% Coinsurance for covered services received during a visit.	\$40 Copay per visit; 20% Coinsurance for covered services received during a visit.	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the deductible .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$20 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: No Charge; Chat/Online visit: No Charge; Video visit: No Charge	Office visit: \$20 Copay per visit; 20% Coinsurance for covered services received during a visit. Phone visit: \$20 Copay per visit; Chat/Online visit: \$20 Copay per visit; Video visit: \$20 Copay per visit	Office visit: 40% Coinsurance Phone visit: 40% Coinsurance; Chat/Online visit: 40% Coinsurance; Video visit: 40% Coinsurance	Group visit 50% of individual visit copay. Copay not subject to the deductible .
	Inpatient services	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you are pregnant	Office visits	20% Coinsurance	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
	Childbirth/delivery professional services				
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	40% Coinsurance	Plan Provider: limited to less than 8 hours per day and 28 hours per week. PAR and Non-PAR Provider: limited to 60 combined visits per calendar year. Non-Plan Provider: 20% penalty without pre-certification.
	Rehabilitation services	Inpatient services: 20% Coinsurance; Outpatient services: \$20 Copay per visit	Inpatient services: Not Covered; Outpatient services: \$20 Copay per visit	Inpatient services: Not Covered; Outpatient services: 40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. Plan provider: outpatient visits limited to 20 visits per therapy per year; inpatient in a multi-disciplinary facility limited to 60 days per condition per year. PAR and Non-PAR Provider: combined outpatient visits limited to 20 visits per therapy per year. Non-Plan Provider: 20% penalty without pre-certification. Copay not subject to the deductible .
	Habilitation services	\$20 Copay per visit	\$20 Copay per visit	40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. Plan Provider: outpatient visits limited to 20 visits per therapy per year; PAR and Non-PAR Provider: combined outpatient visits limited to 20 visits per therapy per year. Non-Plan Provider: 20% penalty without pre-certification. Copay not subject to the deductible .
	Skilled nursing care	20% Coinsurance	Services are covered at the Plan Provider level	Services are covered at the Plan Provider level	Limited to 100 days per year. Non-Plan Provider: 20% penalty without pre-certification.
	Durable medical equipment	20% Coinsurance	Not covered except for the replacement of an arm or leg (20% Coinsurance)	Not covered except for the replacement of an arm or leg (20% Coinsurance)	Coverage is limited to items on our DME formulary. Plan and PAR Provider: prosthetic arms and legs at 20% Coinsurance; not subject to the deductible . Non-PAR Provider: prosthetic arms and legs at 20% Coinsurance. Non-Plan Provider: 20% penalty without pre-certification.
	Hospice services	No Charge	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification. Plan Provider: Not subject to the deductible .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	For services with an ophthalmologist see "Specialist visit". Copay not subject to the deductible .
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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 .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery Hearing aids with limits (Adults) 	<ul style="list-style-type: none"> Infertility treatment Long Term Care/Custodial Nursing Home Care Non-emergency care when traveling outside the U.S. Routine Dental Services 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Bariatric surgery (Plan Provider only) 	<ul style="list-style-type: none"> Chiropractic care (Plan and Par Provider only) Hearing aids with limits 	<ul style="list-style-type: none"> Private-Duty Nursing (Plan Provider only) Routine eye care

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: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*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)

- n The [plan's](#) overall [deductible](#) \$500
- n [Specialist \[copay\]](#) \$40
- n [Hospital \(facility\) \[coinsurance\]](#) 20%
- n [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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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

- n The [plan's](#) overall [deductible](#) \$500
- n [Specialist \[copay\]](#) \$40
- n [Hospital \(facility\) \[coinsurance\]](#) 20%
- n [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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,160

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

- n The [plan's](#) overall [deductible](#) \$500
- n [Specialist \[copay\]](#) \$40
- n [Hospital \(facility\) \[coinsurance\]](#) 20%
- n [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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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 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.

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, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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**).

(Amharic) :

1-800-632-9700 (TTY: **711**).

قبرغا (Arabic) ةظوح م: اذا بتك تديت تيرجا، رفل تامدخ
ةدعل لها تيوتها فانت لى ناج ليلك. لصتا قىب **1-800-632-9700**
(TTY: **711**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké
m̀ Bàsòò-wùdù-po-nyó jũ ní, níí, à wudù kà kò dò po-poò
??in m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **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)。

یسراف (Farsi) هجوت: گاب زبلز یسرفک وگشگ یم یوگ،
تلطیس ت یزبلز ترصب نگیار یاب اش اف مه یم شریک لب.
1-800-632-9700 (TTY: 711) س انب تیوگب.

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 asu Igbo, oru enyemaka asusu, n'efu, diji gi.
Kpoo **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。

(Korean) :

1-800-632-9700 (TTY: 711)

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánífti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

(Nepali) :

1-800-632-9700)TTY: 711(

Afaan Oromoo (Oromo) XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa **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

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado and Kaiser Permanente Insurance Company
NAME OF PLAN	Adams 12 Five Star Schools POS 500 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Point of Service Plan (POS)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

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
4. Annual Deductible Type	<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>
5. Out-of-Pocket Maximum	<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</p>

	2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments for Essential Health Benefits.
7. Is pediatric dental covered by this plan?	No.
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

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

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

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874

Denver/Boulder: 1-303-338-3820

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