This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org or by calling 1-855-249-5005.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,500** person **/ $9,000** family Does not apply to Preventive services and prescription drugs do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Prescription Drugs: **$ 500** person 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.
Is there an out–of–pocket limit on my expenses?	For **preferred providers** **$6,350** person / **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.kp.org **or call 1-855-249-5005**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 Copay	Not Covered	Copay not subject to the deductible. 20% coinsurance for covered services received during a visit.
	Specialist visit	$70 Copay	Not Covered	Copay not subject to the deductible. 20% coinsurance for covered services received during a visit.
	Other practitioner office visit	Not Covered	Not Covered	Other practitioners are defined as chiropractors and acupuncture services.
	Preventive care/screening/immunization	No Charge	Not Covered	Not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$500 Copay	Not Covered	Multiple cost shares may apply per encounter.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary.	Generic drugs	Retail:$25 Copay Mail Order:$50 Copay	Not Covered	No charge for contraceptive drugs and certain over the counter items as required by Federal mandate. Not subject to the pharmacy or "overall" deductible.
	Preferred brand drugs	45% Coinsurance	Not Covered	No charge for contraceptive drugs. Not subject to the "overall" deductible. Subject to formulary guidelines.
	Non-preferred brand drugs	50% Coinsurance	Not Covered	Must be authorized through the non-preferred drug process. No charge for contraceptive drugs. Not subject to the "overall" deductible. Subject to formulary guidelines.
	Specialty drugs	50% Coinsurance	Not Covered	With up to $250 member cost share per prescription drug. No charge for contraceptive drugs. Not subject to the "overall" deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	——————none——————
	Physician/surgeon fees	20% Coinsurance	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	——————none——————
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	——————none——————
	Urgent care	$100 Copay	Not Covered	Urgent care defined as "after-hours" care. Copay not subject to the deductible. 20% coinsurance for covered services received during a visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	——————none——————
	Physician/surgeon fee	20% Coinsurance	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 Copay	Not Covered	Group visit 50% of individual visit. Copay not subject to the deductible. 20% coinsurance for covered services received during a visit.
	Mental/Behavioral health inpatient services	20% Coinsurance	Not Covered	——————none——————
	Substance use disorder outpatient services	$50 Copay	Not Covered	Group visit 50% of individual visit. Copay not subject to the deductible. 20% coinsurance for covered services received during a visit.
	Substance use disorder inpatient services	20% Coinsurance	Not Covered	Limited to medical detoxification; Inpatient residential rehabilitation not covered.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	Not Covered	Limited to routine prenatal visits and one postpartum visit.
	Delivery and all inpatient services	20% Coinsurance	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient:20% Coinsurance Outpatient:$50 Copay	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient:Combined outpatient visit limit between rehabilitation and habilitation services of 40 visits per therapy per year, autism spectrum disorders are not subject to visit limits.
	Habilitation services	$50 Copay	Not Covered	Combined visit limit between rehab/habilitation of 40 visits per therapy per year, autism spectrum disorders are not subject to visit limits.
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Prosthetic arms and legs not subject to the deductible. Coverage is limited to items on our DME formulary.
	Hospice service	20% Coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	$50 Copay	Not Covered	Limited to routine refractive eye exams for members up to the age of 19; 20% coinsurance for covered services received during a visit; Copay not subject to the deductible.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	No Charge	Not Covered	Limited to members up to the age of 19; limited coverage for diagnostic and preventive services, minor restorative (filings), simple extractions and crowns.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric Surgery • Chiropractic Care • Cosmetic Surgery	• Infertility Treatment • Long-Term/Custodial Nursing Home Care • Non-Emergency Care when Travelling Outside the U.S. • Routine Dental Services (Adult)	• Routine Eye Exam (Adult) • Routine Foot Care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Hearing Aids with limits	• Private-Duty Nursing	• Routine Hearing Tests

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-249-5005. You may also contact your state insurance department at 303-894-7490 (in-state, toll-free: 1-800-930-3745.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-855-249-5005.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.**

Language Access Services:

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

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874 Denver/Boulder: 1-303-338-3820

CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD Colorado Springs: 1-800-521-4874 Denver/Boulder: 1-303-338-3820

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874 Denver/Boulder: 1-303-338-3820

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,220
- **Patient pays** $5,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,500
Co-pays	$ 20
Co-insurance	$ 600
Limits or exclusions	$ 200
Total	**$5,320**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,420
- **Patient pays** $1,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$ 100
Co-pays	$1,500
Co-insurance	$ 300
Limits or exclusions	$ 80
Total	**$1,980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Colorado Supplement to the Summary of Benefits and Coverage Form

Kaiser Foundation Health Plan of Colorado

Name of Carrier

KP CO Bronze 4500/50/Dental - OXE

Name of Plan

Individual Policy

Policy Type

TYPE OF COVERAGE

1. Type of plan.	Health maintenance organization (HMO)
2. Out-of-network care covered? [1]	Only for emergency care
3. Areas of Colorado where plan is available.	Plan is available **only** in the following counties as determined by zip code: For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; For Northern Colorado: Adams, Larimer, Morgan, and Weld

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	What this means.
4. Deductible Period	Calendar year	Calendar year deductibles restart each January 1.
5. Annual Deductible Type	Individual/Family	"Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").
6. 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)	

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. [2]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
10. 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.
11. Does the plan have a binding arbitration clause?	Yes	

Asistencia en español

Para obtener esta información escrita en español o para servicios de interpretación, llame al 1-855-249-5005; para TTY/TDD Colorado Springs: 1-800-521-4874; Denver/Boulder: 1- 303-338-3820

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org.

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

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: insurance@dora.state.co.us

Endnotes

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.