KAISER PERMANENTE® : **State of Colorado HDHP 1750 AGG 25%** **Coverage for: Individual / Family | Plan Type: HDHP**

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?	$1,750 Individual / $3,500 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 Self only enrollment, $8,000 for any one member within a Family enrollment, $10,000 for an entire 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, health care this plan doesn't cover, and services indicated in chart starting 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.

Important Questions	Answers	Why this Matters:
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	25% coinsurance	Not covered	Virtual Care Services: No charge
	Specialist visit	25% coinsurance	Not covered	Virtual Care Services: No charge
	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 More information about prescription drug coverage is available at http://www.kp.org/formulary	Generic drugs	$10 retail and $20 mail order / prescription.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive and contraceptive drugs in all tiers are no charge, deductible does not apply.
	Preferred brand drugs	$40 retail and $80 mail order / prescription.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	$60 retail and $120 mail order / prescription.	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	20% coinsurance up to $120 retail / prescription.	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)	25% coinsurance	Not covered	None
	Physician/surgeon fees	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	25% coinsurance	Not covered	Non-Plan Providers covered when temporarily outside the service area: 20% coinsurance.
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

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 mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Annual Wellness Visit: No charge, deductible does not apply. Virtual Care Services: No charge.
	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
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. 120 visit limit / year.
	Rehabilitation services	Outpatient services: 25% coinsurance. Inpatient services: 25% coinsurance.	Not covered	Outpatient: 20 visit limit / therapy / year (autism spectrum disorders not subject to visit limit). Autism spectrum disorders: No charge. Virtual Care Services: No charge. Inpatient: Limited to 60 days / condition / year.
	Habilitation services	Outpatient services: 25% coinsurance	Not covered	20 visit limit / therapy / year (autism spectrum disorders not subject to visit limit). Autism spectrum disorders: No charge. Virtual Care Services: No charge.
	Skilled nursing care	25% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	25% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice service	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 your child needs dental or eye care	Children's eye exam	25% coinsurance	Not covered	Limited to members up to the end of the year in which the member turns 19.
	Children's glasses	25% coinsurance	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	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.)

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (20 visit limit/year)
- Bariatric surgery
- Chiropractic care (20 visit limit/year)
- Hearing aids (Adults: $1,000 limit/ear, every 36 months: up to age 18: 1 aid / ear / 60 months)
- Infertility treatment
- Private-duty nursing (Inpatient)
- Routine eye care (Adult)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

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

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or insurance@dora.state.co.us

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)

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** **$3,500**
- **Specialist coinsurance** **25%**
- **Hospital (facility) coinsurance** **25%**
- **Other 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	$3,500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,770**

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

- **The plan's overall deductible** **$1,750**
- **Specialist coinsurance** **25%**
- **Hospital (facility) coinsurance** **25%**
- **Other 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	$1,750
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,450**

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

- **The plan's overall deductible** **$1,750**
- **Specialist coinsurance** **25%**
- **Hospital (facility) coinsurance** **25%**
- **Other 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	$1,750
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,060**

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

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Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	State of Colorado HDHP 1750 AGG 25%
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: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld. ***KP Select Plan:*** *El Paso 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.

	Description
4. Annual Deductible Type	AGGREGATE DEDUCTIBLE INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET 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. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.

7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, screening and/or imaging, 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
9. 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 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.
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.
SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).
Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

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

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

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, 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**.

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) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

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

Ɓăsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn 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** ）。

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

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) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **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.

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

नेपाली (Nepali) ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: 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**).