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 or TTY 1-800-521-4874.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual / **$500** family; Does not apply to preventive care services, certain services with copays and prescription drugs.	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?	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.
Is there an out–of–pocket limit on my expenses?	Yes, **$2,500** individual / **$5,000** 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; (certain other services may not apply to the out-of-pocket maximum)	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, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	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**.

Questions: Call 1-855-249-5005 (TTY 1-800-521-4874) or visit us at www.kp.org**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) to request a copy.

- **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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$40 copay per visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Other practitioner office visit	Spinal manipulations: Not covered; Acupuncture services: Not covered	Not covered	Other practitioners are defined as spinal manipulations and acupuncture services.
	Preventive care / screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 10% coinsurance; Lab: No charge	Not covered	Diagnostic lab services: not subject to the overall deductible except when provided in the outpatient department of a hospital; 10% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	$100 per test	Not covered	Not subject to the overall deductible; multiple cost shares may apply per encounter.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
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	$15 / retail prescription; $30 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy.
	Brand drugs	$40 / retail prescription; $80 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	Not covered	Not covered	Not subject to the overall deductible. Except those prescribed and authorized through the non-preferred drug process (subject to the brand copay); infertility drugs not covered.
	Specialty drugs	20% coinsurance up to $250 per drug dispensed retail and mail order prescriptions	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	---none---
	Physician/surgeon fees	10% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	$150 per visit	$150 per visit	Does not include imaging (CT/PET Scans, MRIs). Not subject to the overall deductible.
	Emergency medical transportation	10% coinsurance up to $500 per trip	10% coinsurance up to $500 per trip	Not subject to the overall deductible.
	Urgent care	$50 copay per visit (10% coinsurance for covered services received during a visit)	$50 copay per visit (10% 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 overall deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	---none---
	Physician/surgeon fee	10% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit; group visits are 50% of the individual visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$25 copay per visit; group visits are 50% of the individual visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	10% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	10% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	$25 per visit for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. Not subject to the overall deductible.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	10% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	10% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance
	Hospice service	10% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$25 copay per visit for routine refractive exam (10% coinsurance for covered services received during a visit)	Not covered	For services with an ophthalmologist see "Specialist visit"; Copay not subject to the overall deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

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
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Habilitation services
- Hearing aids (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Spinal manipulations
- 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.)

- Bariatric surgery
- Hearing aids (Children under the age of 18)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 1-800-521-4874. 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.

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: The plan at 1-855-249-5005 or TTY 1-800-521-4874; 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 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

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 does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet 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** $6,320
- **Patient pays** $1,220

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	$300
Copays	$20
Coinsurance	$700
Limits or exclusions	$200
Total	**$1,220**

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

Amount owed to providers: $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

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	$0
Copays	$900
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,280**

Total amounts above are based on subscriber only coverage.

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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