**The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.**

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

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Plan provider: $0; PAR provider: $1,000 Individual / $3,000 Family; Non-PAR provider: $1,200 Individual / $3,600 Family. Does not apply to preventive care services.</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. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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>Plan provider: $2,000 Individual / $4,500 Family; PAR provider: $4,000 Individual / $8,000 Family; Non-PAR provider: $7,000 Individual / $14,000 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, balanced-billed charges and 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 or 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>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Plan Provider (You will pay the least)</th>
<th>What You Will Pay</th>
<th>Non-PAR provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 Copay per visit</td>
<td>$25 Copay per visit; 20% Coinsurance for covered services received during a visit.</td>
<td>50% Coinsurance</td>
<td>Copay not subject to the deductible.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 Copay per visit</td>
<td>$40 Copay per visit; 20% Coinsurance for covered services received during a visit.</td>
<td>50% Coinsurance</td>
<td>Copay not subject to the deductible.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>No Charge</td>
<td>$70 Copay per visit</td>
<td>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. PAR provider: not subject to the deductible. Non-PAR: Copay not subject to the deductible.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: No Charge Lab: No Charge</td>
<td>During office: No Charge; Freestanding clinic and outpatient department of a hospital: 20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>PAR Provider: Diagnostic lab and x-ray services not subject to the deductible when provided during an office visit.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 Copay per test</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Plan Provider: Multiple cost shares may apply per encounter. PAR and Non-PAR Provider: 20% penalty without pre-certification.</td>
</tr>
</tbody>
</table>

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.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Plan Provider (You will pay the least)</td>
<td>Subject to formulary guidelines; Plan and PAR provider: Non-preferred brand drugs: except those prescribed and authorized through the non-preferred drug process (subject to the brand copay). 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.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.kp.org">www.kp.org</a></td>
<td>Preferred brand drugs</td>
<td>PAR Provider (You will pay more)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Non-PAR provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Retail: $15 Copay; Mail Order: $30 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $25 Copay; Mail Order: $50 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $50% Coinsurance; Mail Order: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $30 Copay; Mail Order: $60 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $35 Copay; Mail Order: $70 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: 50% Coinsurance; Mail Order: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $75 Copay; Mail Order: $75 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: $75 Copay; Mail Order: $75 Copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail: 50% Coinsurance; Mail Order: Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance up to $500</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 Copay per visit</td>
<td>Non-Plan Providers: only covered if you are out of the service area.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without precertification.</td>
</tr>
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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.
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<th>PAR Provider <em>(You will pay more)</em></th>
<th>Non-PAR provider <em>(You will pay the most)</em></th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$25 Copay per visit</td>
<td>$25 Copay per visit; 20% Coinsurance for covered services received during a visit.</td>
<td>50% Coinsurance</td>
<td>Group visit 50% of individual visit copay. Copay not subject to the <em>deductible</em>.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without pre-certification.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Non-Plan Provider: 20% penalty without pre-certification.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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<th>PAR Provider (You will pay more)</th>
<th>Non-PAR Provider (You will pay the most)</th>
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<tr>
<td><strong>Home health care</strong></td>
<td></td>
<td>No Charge</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>Inpatient services: 20% Coinsurance; Outpatient services: $25 Copay per visit</td>
<td>Inpatient services: Not Covered; Outpatient services: $25 Copay per visit</td>
<td>Inpatient services: Not Covered; Outpatient services: 50% Coinsurance</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>$25 Copay per visit</td>
<td>$25 Copay per visit</td>
<td>50% Coinsurance</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>Limited to 100 days per year. Non-Plan Provider: 20% penalty without pre-certification.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>20% Coinsurance</td>
<td>Not covered except for the replacement of an arm or leg (20% Coinsurance)</td>
<td>Not covered except for the replacement of an arm or leg (20% Coinsurance)</td>
<td></td>
<td>Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% coinsurance. Non-Plan Provider: 20% penalty without pre-certification.</td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td>No Charge</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td></td>
<td>Non-Plan Provider: 20% penalty without pre-certification.</td>
</tr>
<tr>
<td><strong>Children’s eye exam</strong></td>
<td>$25 Copay per visit</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>For services with an ophthalmologist see “Specialist visit”.</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.
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<tbody>
<tr>
<td></td>
<td></td>
<td>Plan Provider</td>
<td>PAR Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay more)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</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.):**

- Acupuncture
- 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.):**

- Bariatric surgery (Plan Provider only)
- Chiropractic care (Plan and PAR Provider only)
- Hearing aids with limits
- Infertility treatment (Plan Provider only)
- Private-Duty Nursing (Plan Provider only)
- Routine eye care (Plan Provider only)
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The plan’s overall deductible</td>
<td>$0</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>- Hospital (facility) [coinsurance]</td>
<td>20%</td>
<td>Hospital (facility) [coinsurance]</td>
</tr>
<tr>
<td>- Other [coinsurance]</td>
<td>20%</td>
<td>Other [coinsurance]</td>
</tr>
</tbody>
</table>

**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)

**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)

**This EXAMPLE event includes services like:**
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
<th>Total Example Cost</th>
<th>$7,400</th>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

**In this example, Peg would pay:**

| Cost Sharing | Deductibles | $0 | Copayments | $40 | Coinsurance | $1,800 |
|---|---|---|---|---|---|

**What isn’t covered**
- Limits or exclusions | $60
- The total Peg would pay is | $1,900

**In this example, Joe would pay:**

| Cost Sharing | Deductibles | $0 | Copayments | $900 | Coinsurance | $300 |
|---|---|---|---|---|---|

**What isn’t covered**
- Limits or exclusions | $60
- The total Joe would pay is | $1,260

**In this example, Mia would pay:**

| Cost Sharing | Deductibles | $0 | Copayments | $200 | Coinsurance | $300 |
|---|---|---|---|---|---|

**What isn’t covered**
- Limits or exclusions | $0
- The total Mia would pay is | $500

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.


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).

العربية (Arabic) ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك الرأيك. تصل برقم 1-800-632-9700 (TTY: 711).

Ɓăsɔ́ɔ }_${̀̀ Ɓàsɔ́ɔ (Bassa) Dë që nià ke dyédé gbo: Ɔ jëdu ke m Bàsɔ́ɔ-wùqù-po-nyò jù ní, níi, à wùqù kà ko dò po-poò béèin m gbo kpàá. Ìjà 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 گردد. 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).


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.


Nepali (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईले नेपाली भाषा सहयोग सेवाहरू निश्चित रूपमा उपलब्ध छ। 1-800-632-9700 (TTY: 711) फोनले गर्नुहोस्।
# Colorado Supplement to the Summary of Benefits and Coverage Form

<table>
<thead>
<tr>
<th>INSURANCE COMPANY NAME</th>
<th>Kaiser Foundation Health Plan of Colorado and Kaiser Permanente Insurance Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PLAN</td>
<td>University of Denver Triple Option</td>
</tr>
</tbody>
</table>

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.**
   - 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 Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller;
   - For Northern Colorado: Adams, Larimer, Morgan, and Weld;
   - 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.

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Annual Deductible Type</strong></td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>5. Out-of-Pocket Maximum</strong></td>
</tr>
<tr>
<td>EMBEDDED OUT-OF-POCKET</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>6. What is included in the In-Network Out-of-Pocket Maximum?</strong></td>
</tr>
<tr>
<td>Coinsurance and copayments for Essential Health Benefits.</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.</td>
<td></td>
</tr>
</tbody>
</table>

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

**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 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