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. Please read the FEHB Plan brochure (RI 73-019) that contains the complete terms of this plan. All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-855-249-5005 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Self Only $600 / Self Plus One $600 / Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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	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 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?	$7,000 / person up to $14,000 / family	The out-of-pocket limit, or catastrophic maximum, 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, balance-billing charges, 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/feds or call 1-855-249-5005 (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?	Yes.	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		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit; deductible does not apply.	Not covered	You pay $300 for drugs administered in connection with your care.
	Specialist visit	$35 / visit; deductible does not apply. 20% coinsurance for procedures received during a visit.	Not covered	You pay $300 for drugs administered in connection with your care.
	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 you need are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $35 / visit; Lab: No charge, deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$250 / procedure per body part	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Preferred generic drugs	$15 (retail); $30 (mail order) / prescription; deductible does not apply.	Not covered	Preventive maintenance: $5 (retail); $10 (mail order) / prescription; deductible does not apply. Up to 30-day supply (retail) or 90-day supply (mail order). Subject to formulary guidelines. Prescriptions for second fill and maintenance medications must be filled at a pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Federally mandated over the counter items are covered with a prescription. No charge, deductible does not apply for women's preventive contraceptives, in accordance with formulary guidelines.
	Preferred brand drugs	$60 (retail); $120 (mail order) / prescription; deductible does not apply.	Not covered	
	Non-preferred drugs	$80 (retail); $160 (mail order) / prescription; deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Prescriptions for second fill and maintenance

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
				medications must be filled at a pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Must be authorized through the exception drug process.
	Specialty drugs	$300 (retail) / prescription; deductible does not apply.	Not covered	Up to 30-day supply (retail). Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: $275 / surgery; Outpatient hospital: $375 / surgery	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$375 / visit	$375 / visit	None
	Emergency medical transportation	$250 / trip	$250 / trip	None
	Urgent care	$35 / visit; deductible does not apply.	$35 / visit; deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / individual visit; deductible does not apply.	Not covered	$5 / group visit; deductible does not apply.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge; deductible does not apply.	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
	Home health care	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: $10 / visit, deductible does not apply. Inpatient: 20% coinsurance	Not covered	Outpatient: 20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). Inpatient rehabilitation facility: Limited to 60 days / condition / year.
	Habilitation services	$10 / visit; deductible does not apply.	Not covered	20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	100 day limit / year.
	Durable medical equipment	20% coinsurance; deductible does not apply.	Not covered	Subject to formulary guidelines.
	Hospice services	Home based: No charge; Inpatient: 20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	$10 / visit; deductible does not apply.	Not covered	For services with an ophthalmologist, see "Specialist visit."
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Eyeglasses
- Long-term care
- Non-emergency care when traveling outside of the U.S. See the FEHB Plan Brochure for information
- Private-duty nursing
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Habilitation
- Hearing aids (Up to age 18)
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 855-249-5005 (TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy),

spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: 1-855-249-5005 (TTY: 711).

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).
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).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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 $300
- Specialist copayment $35
- Hospital (facility) coinsurance 20%
- Other (blood work) coinsurance 0%

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	$300
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,070

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

- The plan's overall deductible $300
- Specialist copayment $35
- Hospital (facility) coinsurance 20%
- Other (blood work) coinsurance 0%

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	$0
Copayments	$1,100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,300

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

- The plan's overall deductible $300
- Specialist copayment $35
- Hospital (facility) coinsurance 20%
- Other (x-ray) copayment $35

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	$300
Copayments	$400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$780

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**).

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 ɓɛ́ìn m̀ gbo kpáa. Ɖá **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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको 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**).