KAISER PERMANENTE®*: University of Denver Triple Option **Coverage Period: 07/01/2015 - 06/30/2016**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

*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.

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?	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, services with copays and prescription drugs.	Plan provider: See the chart starting on page 2 for your costs for services this plan covers. PAR and Non-PAR provider: 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?	Plan provider: No PAR provider: No; Non-PAR provider: 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, 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	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, health care this plan doesn't cover, and deductible; (certain 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**.

- **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 Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 per visit	$25 per visit (20% coinsurance for covered services received during a visit)	50% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Specialist visit	$40 per visit	$40 per visit (20% coinsurance for covered services received during a visit)	50% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Other practitioner office visit	$20 per visit for Spinal manipulation. Acupuncture services not covered.	$40 per visit for Spinal manipulation. Acupuncture services not covered.	Not covered	Other practitioners are defined as Spinal manipulation and acupuncture services. PAR provider: copay not subject to the deductible; 20 visits per year for Spinal manipulation; limited to spinal manipulation only. Plan provider: 20 visits per year for chiropractic services.
	Preventive care/ screening/ immunization	No charge	No charge	$70 per visit	PAR and Non-PAR provider: not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	$100 copay per procedure	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) 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	$25 / retail prescription; $50 / mail order prescription	$25 / retail prescription	Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible. Subject to formulary guidelines. 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.
	Brand drugs	$25 / retail prescription; $50 / mail order prescription	$35/retail prescription; $70/mail order prescription	$35 / retail prescription	Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible. Subject to formulary guidelines.
	Non-preferred drugs	Not covered	Not covered	Not covered	Except those prescribed & authorized through the non-preferred drug process (subject to brand copay). Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Cost share for generic, brand or non-preferred drugs may apply	Cost share for generic, brand or non-preferred drugs may apply	Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per surgery	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Physician/surgeon fees	See Facility fee under "If you have outpatient surgery"	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification
If you need immediate medical attention	Emergency room services	$100 per visit	See coverage under plan provider	See coverage under plan provider	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted as an inpatient.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
	Emergency medical transportation	20% coinsurance up to $500 per trip	See coverage under plan provider	See coverage under plan provider	---none---
	Urgent care	$50 per visit	20% coinsurance	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Physician/surgeon fee	See Facility fee under "If you have a hospital stay"	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 per visit	$25 per visit (20% coinsurance for covered services received during a visit)	50% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Mental/Behavioral health inpatient services	$500 copay per admission	20% coinsurance	50% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Substance use disorder outpatient services	$25 per visit	$25 per visit (20% coinsurance for covered services received during a visit)	50% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Substance use disorder inpatient services	$500 copay per admission	20% coinsurance	50% coinsurance	PAR and Non-PAR provider: limited to acute detoxification. Non-PAR provider: 20% penalty without pre-certification
If you are pregnant	Prenatal and postnatal care	$0 per visit	20% coinsurance	50% coinsurance	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. PAR provider: copay not subject to the deductible.
	Delivery and all inpatient services	$500 copay per admission	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	50% coinsurance	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-PAR provider: 20% penalty without pre-certification.
	Rehabilitation services	$25 per visit for outpatient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Outpatient: 20% coinsurance; Inpatient: Not covered	Outpatient: 50% coinsurance; Inpatient: Not covered	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-PAR provider: 20% penalty without pre-certification.
	Habilitation services	Not covered	Not covered	Not covered	---none---
	Skilled nursing care	No charge	Not covered	Not covered	Limited to 100 days per year. . Non-PAR provider: 20% penalty without pre-certification.
	Durable medical equipment	20% coinsurance	Not covered except for the replacement of an arm or leg (20% coinsurance)	Not covered except for the replacement of an arm or leg (20% coinsurance)	Plan provider: limited coverage pursuant to federal and state mandates; prosthetic arms and legs at 20% coinsurance. Non-PAR provider: 20% penalty without pre-certification
	Hospice service	No charge	20% coinsurance	50% coinsurance	Non- PAR provider: 20% penalty without pre-certification
If your child needs dental or eye care	Eye exam	$25 per visit for refractive exams	Not covered	Not covered	For services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	Not covered	---none---
	Dental check-up	Not covered	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
- 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 (Plan provider only)
- Hearing Aids (Children under the age of 18)
- Infertility treatment (Plan provider only)
- Private duty nursing (Plan provider only)
- Routine eye care (Adult – Plan Provider only)
- Spinal manipulation (Plan and PAR provider only)

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.

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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** $6,840
- **Patient pays** $700

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	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

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 plan provider and subscriber only coverage.

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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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