KAISER PERMANENTE®: Littleton Public Schools DHMO 200

Coverage for: Individual/Family | Plan Type: HMO

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 1-800-249-5005 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/.com or call 1-800-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 Individual / $400 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 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 and hospice	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,000 Individual / $6,000 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, balanced-billed charges and 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.com or call 1-855-249-5005 or 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?	No.	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	Not Covered	Copay not subject to deductible.
	Specialist visit	$40 Copay per visit	Not Covered	Copay not subject to deductible.
	Preventive care/screening/ immunization	No Charge	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 for. Not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: 20% Coinsurance	Not Covered	Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; 20% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	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	Generic drugs	Retail: $20 Copay; Mail Order: $40 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs: except those prescribed and authorized through the non-preferred drug process (subject to the brand copay). For Southern Colorado members: 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 when filled at a Kaiser Permanente pharmacy. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: $40 Copay; Mail Order: $80 Copay	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., ambulatory surgery center)	Not Covered	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% coinsurance up to $500	20% coinsurance up to $500	Not subject to deductible.

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)	
	Urgent care	$40 Copay per visit	$40 Copay per visit	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay per visit	Not Covered	Group visit 50% of individual visit copay. Copay not subject to deductible.
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

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)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: $20 Copay per visit	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.
	Habilitation services	$20 Copay per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible.
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance.
	Hospice services	No Charge	Not Covered	Not subject to deductible.
If your child needs dental or eye care	Children's eye exam	$20 Copay per visit	Not Covered	For services with an ophthalmologist see "Specialist visit". Copay not subject to deductible.
	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 policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- 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
- Chiropractic care
- Hearing aids with limits
- Infertility treatment
- Private-Duty Nursing
- Routine eye care

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$40
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,800

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,360

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$30
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$430

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

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 the number provided below.

Colorado	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 with the Kaiser Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, telephone number: 1-800-632-9700. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. 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

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or this notice requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሰር ፐርማነንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።
Colorado 1-800-632-9700 (TTY 711)

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو يتطلب هذا الإشعار منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.
Colorado 1-800-632-9700 (TTY 711)

Bassa (Bassa): Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ̀ ɓé m̀ ké gbo-kpá-kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɔ jǔ ké m̀ dyi dyi-dieǹ-ɖè ɓě ɓéɖé ɓá nì ɖɛ-mó-ɖîfèɖèɔ̀ dyí, mɔɔ ɓá nì kũùn kpɔ̃ jè dyí dyììn ɖé Kaiser Permanente mú, mɔɔ ɔ jǔ ké bɔ̃̌i-po-po nìà kɛ dyi níiń m̀ mɛ nyùìn ɖɛ dò wé jéɛ́ dò kɔ̃ɛ nì, nìí, ɖá nɔ̀ɓà ɓɛ́ wa tòà ɓó nì gbɛ̌ɛ̀ vènè mɔɔ nì gbɛ̌ɛ̀ dyùɔ̀ jèɛ ɓɛ́ m̀ ké wuɖu-zĩ̀ìn-nyɔ̀ ɖò gbo wùɖù.
Colorado 1-800-632-9700 (TTY 711)

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。
Colorado 1-800-632-9700 (TTY 711)

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.
Colorado 1-800-632-9700 (TTY 711)

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.
Colorado 1-800-632-9700 (TTY 711)

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ na ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị iji kwukọrịta okwu n'etiti onye ọkọwa okwu.
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日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳と, お話ください。
Colorado 1-800-632-9700 (TTY 711)

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다.
Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 일정 날짜까지 조취를 취해야 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.
Colorado 1-800-632-9700 (TTY 711)

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

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Naabeehó (Navajo): T’áá ni nizaad bee níká i’doolwoł doo bik’é asíníłáágóó éí bee náhaz’ą́. Kaiser Permanente áká aná’álwo’ ná bik’é azláadoo yíníkeedgo naaltsoos hadinilaa, éí bína’ídíłkid doogo, éí doodago díí naaltsoos haa’ída yoołkáałgo hait’áoda í’díílíił niłníigo éí nitsaa hahoodzojí éí doodago t’áá aadi nahós’a’di ata’ dahalne’ígíí bich’į’ hólne’go bee bił ahił hodíílnih.
Colorado 1-800-632-9700 (TTY 711)

नेपाली (Nepali): तपाईंसगं कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाठने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नुपरेमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्वरमा कल गर्नुहोस् ।
Colorado 1-800-632-9700 (TTY 711)

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa’ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan beeksisi Kun guyyaa murtaa’e irratti tarkaanfii akka ati fudhattu kan gaafatu yoo ta’e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bibiluudhaan turjumaana haasofisiisi.
Colorado 1-800-632-9700 (TTY 711)

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سؤالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.
Colorado 1-800-632-9700 (TTY 711)

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо данное уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.
Colorado 1-800-632-9700 (TTY 711)

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o este aviso requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.
Colorado 1-800-632-9700 (TTY 711)

Tagalog (Tagalog): Mayroon kang karapatan na kumuha ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o ang abisong ito ay nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap usap sa tagapagsalin.
Colorado 1-800-632-9700 (TTY 711)

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc thông báo này yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.
Colorado 1-800-632-9700 (TTY 711)

Yorùbá (Yoruba): O ní ètọ́ láti rí ìrànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbéèrè nípa ìṣàfilọ́lẹ̀ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ìfitọnilétí yìí fẹ́ kí gbé ìgbésẹ̀ kan ní ọjọ́ kan patọ́, pé nọ́mbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òǹgbifọ̀ kan sọ̀rọ̀.
Colorado 1-800-632-9700 (TTY 711)

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Littleton Public Schools DHMO 200
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 as determined by **zip code** and employer service area selection: 1. **For Denver/Boulder service area:** Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. **For Southern Colorado:** Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. **For Southern Colorado *KP Select Plan***: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. **For Northern Colorado:** Adams, Larimer, Morgan, and Weld; 5. **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.

INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS LARGE GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS. This means if you live or work outside of the service area where this plan is available, you will have to travel into this service area to receive non-emergency or non-urgent covered services. If you have any questions, please contact 1-855-249-5005 (TTY 711).

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 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 for Essential Health Benefits.
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

	IN-NETWORK	**OUT-OF-NETWORK**
8. 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 are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

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 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