KAISER PERMANENTE®

2008 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
$2,000 Deductible Plan (70%) with Rx, $2,000 Deductible Plan (70%), and $5,000 Deductible Plan (70%)

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Denver and Boulder Counties and portions of Adams, Arapahoe, Broomfield, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties as determined by zip code

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

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4. Deductible Type[2]	Calendar year	Calendar year	Calendar year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	a) $2,000 per calendar year b) $6,000 per calendar year **Note:** The Pharmacy Deductible is separate from the medical Deductible ("Deductible"), noted above. Please see Box 11 for information regarding the Pharmacy Deductible.	a) $2,000 per calendar year b) $6,000 per calendar year	a) $5,000 per calendar year b) $15,000 per calendar year
	The Individual and Family Deductibles are separate Deductibles. For Families, individual family members are responsible for meeting the Family Deductible, only up to the Individual Deductible amount.		
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $5,000 per calendar year b) $10,000 per calendar year c) No, the Out-of-Pocket Maximum ("OPM") excludes Deductible and Copayments For Families, the individual family members are responsible for meeting the Family OPM, only up to the Individual OPM amount		

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Kaiser Foundation Health Plan of Colorado

PART B: SUMMARY OF BENEFITS CONTINUED

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6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum Benefit Maximum(s) Transplant Lifetime Maximum $1,000,000 per Individual; $25,000 Bone Marrow Donor Search per Individual The $25,000 bone marrow donor search does not apply towards the Transplant Lifetime Maximum or the Lifetime Maximum.		
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers		
7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?	Yes		
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	Not subject to Deductible; does not apply to OPM a) $30 Copayment each primary care office visit b) $50 Copayment each specialist care office visit 30% Coinsurance for procedures received during an office visit, after Deductible is met. (**Note:** procedures received during the visit are subject to Deductible; apply toward OPM)		
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Not subject to Deductible; does not apply to OPM a) No Charge (100% covered) b) No Charge (100% covered)		
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	Not Covered		

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11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	Not subject to medical Deductible; does not apply toward OPM $200 Pharmacy Deductible per person $15 Generic/$30 Brand name/50% Non-preferred per prescription up to a 30-day supply, after Pharmacy Deductible is met. Mail-order drugs available for up to a 90-day supply for two Copayments. For drugs on our approved list, please contact your Clinical Pharmacy Call Center at **303-338-4503** or toll-free at **1-800-632-9700** or TTY **1-800-521-4874**.	Not Covered	Not Covered
12. INPATIENT HOSPITAL	Subject to Deductible; applies toward OPM 30% Coinsurance, after Deductible is met. 30% Coinsurance for inpatient professional visits, after Deductible is met.		
13. OUTPATIENT/ AMBULATORY SURGERY	Subject to Deductible; applies toward OPM 30% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met		
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	a) Diagnostic Lab – Not subject to Deductible; does not apply toward OPM No Charge (100% covered) X-ray, including Therapeutic – Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met b) MRI/CT/PET – Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met		

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15. EMERGENCY CARE[7], [8]	Subject to Deductible; applies toward OPM 30% Coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after Deductible is met		
16. AMBULANCE	Not subject to Deductible; does not apply toward OPM 30% Coinsurance up to $500 per trip		
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	a) Urgent care[7] – Subject to Deductible; applies toward OPM 30% Coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after Deductible is met b) Non-routine care – Not subject to Deductible; does not apply toward OPM $30 Copayment each visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan emergency room outside the Service Area, during office hours; 30% Coinsurance for procedures received during the visit, after Deductible is met. (**Note:** procedures received during the visit are subject to Deductible; apply toward OPM) c) After-hours care – Not subject to Deductible; does not apply toward OPM $75 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area; 30% Coinsurance for procedures received during the visit, after Deductible is met. (**Note:** procedures received during the visit are subject to Deductible; apply toward OPM)		
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	See line 19, Other Mental Health Care		
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) Inpatient - Not Covered b) Outpatient – Not subject to Deductible; does not apply toward OPM One consultation per year is provided at a 50% Coinsurance		
20. ALCOHOL & SUBSTANCE ABUSE	a) Inpatient Medical Detoxification – Subject to Deductible; applies toward OPM 30% Coinsurance per admission after Deductible is met. Detoxification is limited to removing toxic substances from the body. Inpatient Residential Rehabilitation - Not Covered b) Outpatient Chemical Dependency – Not subject to Deductible; does not apply toward OPM One consultation per year is provided at 50% Coinsurance		

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Kaiser Foundation Health Plan of Colorado

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21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	For conditions subject to significant improvement within two (2) months *Inpatient – Subject to Deductible; applies toward OPM 30% Coinsurance per admission, after Deductible is met; for physical therapy only. (Occupational and speech therapy are not covered) *Outpatient – Not subject to Deductible; does not apply toward OPM $30 Copayment each visit for up to 20 visits for each type of therapy (i.e., physical, occupational, and speech therapy) *Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. For children ages 0-3 services may be available as part of Early Intervention Services as defined by state law.		
22. DURABLE MEDICAL EQUIPMENT	Not subject to Deductible; does not apply toward OPM No supplemental benefit. Prosthetic arms and legs covered at 20% Coinsurance with no annual maximum benefit		
23. OXYGEN	Not Covered		
24. ORGAN TRANSPLANTS	Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 30% Coinsurance for inpatient professional visits, after Deductible is met		
25. HOME HEALTH CARE	Subject to Deductible; applies toward OPM 30% Coinsurance for prescribed medically necessary part-time home health services, after Deductible is met. Not covered outside the Service Area.		
26. HOSPICE CARE	Subject to Deductible; applies toward OPM 30% Coinsurance for hospice care, after Deductible is met. Not covered outside the Service Area.		
27. SKILLED NURSING FACILITY CARE	Subject to Deductible; applies toward OPM 30% Coinsurance for up to 100 days per year for prescribed skilled nursing facility services at approved skilled nursing facilities, after Deductible is met. Not covered outside the Service Area.		
28. DENTAL CARE	Not Covered		
29. VISION CARE	Not Covered		
30. CHIROPRACTIC CARE	Not Covered		

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Kaiser Foundation Health Plan of Colorado

PART B: SUMMARY OF BENEFITS CONTINUED

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31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; Limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area		

PART C: LIMITATIONS AND EXCLUSIONS

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32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED[10]	Not Applicable. Plan does not impose limitation periods for pre-existing conditions.		
33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No		
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not Applicable. Plan does not exclude coverage for pre-existing conditions.		
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g. employer). Review them to see if a service of treatment you may need is excluded from the policy.		

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Kaiser Foundation Health Plan of Colorado

PART D: USING THE PLAN

	$2,000 DEDUCTIBLE PLAN WITH Rx IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	**$2,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)**	**$5,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)**
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No		
39. What is the main customer service number?	Member Services can be reached at **303-338-3800** or toll-free at **1-800-632-9700** or TTY **1-800-521-4874**		
40. Whom do I write/call if I have a complaint or want to file a grievance? [11]	Member Services 2500 South Havana Street Aurora, CO 80014 **303-338-3800** or toll-free at **1-800-632-9700** or TTY **1-800-521-4874**		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy form KPIF2000Rx-DEN(01-08) Individual	Policy form KPIF2000-DEN(01-08) Individual	Policy form KPIF5000-DEN(01-08) Individual
43. Does the plan have a binding arbitration clause?	Yes		

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Endnotes

[1] "Network" refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand-name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility, that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Colorado Health Benefit Plan Description Form Addendum
Kaiser Permanente Cancer Screening Guidelines
(Charges may apply)

Breast Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Unlimited	As jointly determined by physician and patient
Mammogram	Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider for those women who meet the following criteria: Patients with a 10% or greater risk of inherited gene defect	

Colon and Rectal Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Fecal occult blood test (FOBT)	Unlimited	Annually beginning at age 50 through age 75
Flexible sigmoidoscopy	Unlimited	Every 5 – 10 years beginning at age 50 through age 75
Barium enema	Unlimited	Every 5 years beginning at age 50 through age 75
Colonoscopy	Every 10 years, more frequently for high risk patients — as determined by a Kaiser Permanente physician	Every 10 years, more frequently for high risk patients — as determined by a Kaiser Permanente physician

Cervical Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Unlimited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.

Prostate Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Unlimited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician
Serum prostatic specific antigen (PSA)	Unlimited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician. Not recommended for those over 70.