KAISER PERMANENTE®

2008 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
$30 Copayment Plan – Denver/Boulder

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.

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
4. Deductible Type[2]	Not Applicable
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 a) No Deductibles b) No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	 a) $3,000/Individual b) $7,500/Family c) Not Applicable For Families, the individual family members are responsible for meeting the Family OPM, only up to the Individual OPM amount
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**	 a) $30 Copayment each primary care office visit b) $40 Copayment each specialist office visit Line 13 may apply for procedures performed during an office visit
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	 a) No Charge (100% covered) b) No Charge (100% covered)

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	Not covered
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	Not covered
12. INPATIENT HOSPITAL	20% Coinsurance per admission
13. OUTPATIENT/AMBULATORY SURGERY	$150 Copayment each visit for outpatient surgery performed in any setting other than inpatient
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	a) Diagnostic Lab and X-ray - No Charge (100% covered) Therapeutic X-ray - $40 Copayment each visit b) MRI/CT/PET - $100 Copayment per procedure
15. EMERGENCY CARE[7], [8]	$150 Copayment each visit at a designated Kaiser Permanente emergency room or a non-Plan emergency room– waived if admitted as an inpatient
16. AMBULANCE	20% Coinsurance up to a maximum of $500 per trip
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	a) Urgent care[7] $150 Copayment each visit at a Kaiser Permanente designated Plan emergency room inside the Service Area or a non-Plan emergency room outside the Service Area, waived if admitted as an inpatient b) Non-routine care $30 Copayment each visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area during office hours. c) After-hours care $75 Copayment each after hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area
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 - one consultation per year is provided at a $30 Copayment
20. ALCOHOL & SUBSTANCE ABUSE	a) Inpatient Medical Detoxification – 20% Coinsurance per admission. Detoxification is limited to removing toxic substance from the body. Inpatient Residential Rehabilitation – Not Covered b) Outpatient Chemical Dependency - one consultation per year is provided at a $30 Copayment

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	For conditions subject to significant improvement within two (2) months Inpatient* - 20% Coinsurance per admission for physical therapy only. (Occupational and speech therapy are not covered) Outpatient* - $30 Copayment each visit for up to 20 visits per year 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	No supplemental benefit. Prosthetic arms and legs are covered at a 20% Coinsurance with no annual maximum benefit.
23. OXYGEN	Not covered
24. ORGAN TRANSPLANTS	a) Inpatient – See Box 12, Inpatient Hospital. b) Outpatient – see applicable benefit in this Health Benefit Plan Description Form. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone-marrow, cornea and liver, small bowel/small bowel and liver.
25. HOME HEALTH CARE	$30 Copayment for prescribed medically necessary part-time intermittent home health care services. Not covered outside the Service Area.
26. HOSPICE CARE	20% Coinsurance for hospice care. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	20% Coinsurance for up to 100 days of prescribed skilled nursing services per year at approved skilled nursing facilities. Not covered outside Service Area.
28. DENTAL CARE	Not covered
29. VISION CARE	Not covered
30. CHIROPRACTIC CARE	Not covered
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

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
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

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PART C: LIMITATIONS AND EXCLUSIONS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
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.

PART D: USING THE 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 **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 KPIF30-DENCOS(01-08) Individual
43. Does the plan have a binding arbitration clause?	Yes

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.