Pick the right Endura plan for you

We offer two types of health coverage for individuals and families. Both feature quality care—the main difference is how you pay for it. Many preventive care services are no charge, no matter which plan you choose.

ENDURA DEDUCTIBLE HMO PLANS

- Range of deductible levels
- Office visits for a copay before deductible

With deductible plans, some services, such as office visits and emergency room visits, are available for a copay before you meet the annual deductible.

Our deductible HMO plans:

- KP Deductible HMO 1000/30/Rx
- KP Deductible HMO 1500/30/Rx
- KP Deductible HMO 2000/30/Rx
- KP Deductible HMO 3000/30/Rx
- KP Deductible HMO 3500/40/Rx
- KP Deductible HMO 5000/40/Rx
- KP Deductible HMO 6000/50
- KP Deductible HMO 7500/50

ENDURA HSA-QUALIFIED DEDUCTIBLE HMO PLANS

- Deductible contributes toward out-of-pocket maximum
- Pay for health care with tax-deductible dollars

These plans offer quality medical coverage and a tax-free way to build savings for qualified medical expenses.[1]

Our HSA-qualified deductible HMO plans:

- KP 3500/0/HSA/Rx
- KP 4500/0/HSA/Rx
- KP 5500/0/HSA/Rx

[1]Tax references relate to federal income tax only. Please consult a financial or tax adviser for tax savings information.

QUESTIONS? Contact your broker today!

How deductible HMO plans work

Deductible plans generally offer lower monthly premiums in exchange for paying more out of your own pocket for services covered by your health plan. With these plans, you pay full charge for most covered services until your expenses meet an annual deductible. Then, for covered services, you are eligible to pay coinsurance.

Deductibles

Under a deductible plan, many covered services are subject to the deductible — the set amount for which you pay full charge in a calendar year. This means you'll pay full charge for certain medical services until you reach your annual deductible.

Family deductibles

In a family deductible plan, there are two ways for enrolled family members to meet their deductible:

- Each family member can separately meet the individual deductible.
- The family's combined expenses can meet the family deductible.

No deductible for many services

With most of our deductible HMO plans, many services, such as primary and specialty care visits, urgent care, and generic prescription drugs, are available for a copayment before you meet your deductible.

And to encourage you to receive preventive care, many of these services are available for no charge before you meet your deductible.

Out-of-pocket maximums

Your out-of-pocket maximum puts a cap on how much you'll spend on most covered services each calendar year. This helps protect you financially if you have a serious illness or injury.

In our deductible HMO plans, the deductible does not apply toward the out-of-pocket maximum. You must first meet your deductible before your coinsurance starts to apply to your out-of-pocket maximum.

For example, if you are a single subscriber on the KP Deductible HMO 2000/30/Rx plan, you would pay full charge for most services until your out-of-pocket costs reach $2,000. To reach your $3,750 out-of-pocket maximum, you would pay $3,750 in coinsurance in addition to the $2,000 you paid toward your deductible.

Family out-of-pocket maximums

In a family deductible plan, there are two ways for enrolled family members to meet their out-of-pocket maximum:

- Each family member can separately meet the individual out-of-pocket maximum.
- The family's combined expenses can meet the family out-of-pocket maximum.

QUESTIONS? Contact your broker today!

Using a deductible HMO plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP Deductible HMO 1000/30/Rx plan, you have to pay $1,000 out of your own pocket before you are eligible to pay coinsurance for most covered services.

In this example, even if you have not met your deductible, you would pay only a $30 copayment (or copay) for the doctor's office visit and a $15 copay for the generic drug, because these services are not subject to the deductible under our deductible plans.

However, you would pay full charge for the X-ray. And the amount you pay for the X-ray would be applied to your $1,000 deductible. (After you meet your deductible, you would pay a 30 percent coinsurance for the X-ray.)

Visit the treatment fee tool at **kp.org/treatmentestimates** to estimate your out-of-pocket costs for upcoming services.

The HSA difference

Some of our deductible plans are HSA-qualified deductible plans. These plans can be paired with an optional health savings account, or HSA. HSA-qualified plans work similarly to traditional deductible plans with just a few differences:

- If you're eligible, you can open an HSA with an HSA-qualified plan.
- Money you deposit into your HSA is deductible from your income on your federal income tax form.
- You can use funds from your HSA to pay for qualified medical expenses.
- In traditional deductible plans, the deductible does not apply to the out-of-pocket maximum. In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.
- In HSA-qualified plans with family coverage, there are no individual deductibles or out-of-pocket maximums. The family must meet family deductibles or out-of-pocket maximums.

Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. For more information on health savings accounts, please visit www.irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

QUESTIONS? Contact your broker today!

Benefit highlights

	DEDUCTIBLE HMO PLANS			
	KP DEDUCTIBLE HMO 1000/30/Rx	**KP DEDUCTIBLE HMO 1500/30/Rx**	**KP DEDUCTIBLE HMO 2000/30/Rx**	**KP DEDUCTIBLE HMO 3000/30/Rx**
FEATURES	**Deductible does not contribute to the out-of-pocket maximum. Coinsurance contributes to the out-of-pocket maximum.**			
Annual deductible (individual/family)[1,2]	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000
Annual out-of-pocket maximum (individual/family)[2] (does not include medical or pharmacy deductible)	$3,750/$7,500			
BENEFITS	Services not subject to deductible unless otherwise indicated			
PREVENTIVE CARE				
	Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.			
OUTPATIENT SERVICES (per visit or procedure)				
Primary care/Specialty care office visit	$30 copay/$50 copay			
Ambulatory surgery	30% coinsurance (after deductible)			
Diagnostic lab (in a medical office or contracted free-standing facility)	No charge			
Therapeutic and diagnostic X-ray	30% coinsurance (after deductible)			
INPATIENT HOSPITAL CARE				
Hospital care and professional visits	30% coinsurance (after deductible)			
MATERNITY				
Routine prenatal care visit	No charge			
Delivery and inpatient well-baby care	30% coinsurance (after deductible)			
EMERGENCY AND URGENT CARE				
Emergency room visit	$250 copay			
Nonroutine care	$30 copay			
After-hours care	$75 copay			
Ambulance service	30% coinsurance (up to $500 per trip)			
PRESCRIPTION DRUGS	$200 pharmacy deductible for brand drugs			
Pharmacy (up to a 30-day supply filled at a Kaiser Permanente or affiliated pharmacy)[3]	Generic: $15 copay/Brand: $30 copay			
Mail-order (up to a 90-day supply)[3]	Generic: $30 copay/Brand: $60 copay			

[1]In deductible plans, the deductible does not apply to the out-of-pocket maximum. In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.

[2]For families in a deductible plan, individual family members are responsible for meeting the family deductible and out-of-pocket maximum only up to the individual deductible and out-of-pocket maximum amount, until the family out-of-pocket maximum is met. For family memberships in an HSA-qualified deductible HMO plan, the individual deductible and out-of-pocket maximum do not apply. The family deductible and out-of-pocket maximum can be met by a combination of family members.

[3]There are different copays and coinsurance for nonpreferred and specialty drugs. Prescribed contraceptives are no charge and are not subject to the deductible. See the *Membership Agreement* for specific details.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

QUESTIONS? Contact your broker today!

Benefit highlights

	DEDUCTIBLE HMO PLANS			
	KP DEDUCTIBLE HMO 3500/40/Rx	KP DEDUCTIBLE HMO 5000/40/Rx	KP DEDUCTIBLE HMO 6000/50	KP DEDUCTIBLE HMO 7500/50
FEATURES	**Deductible does not contribute to the out-of-pocket maximum. Coinsurance contributes to the out-of-pocket maximum.**			
Annual deductible (individual/family)[1,2]	$3,500/$7,000	$5,000/$10,000	$6,000/$12,000	$7,500/$15,000
Annual out-of-pocket maximum (individual/family)[2] (does not include medical or pharmacy deductible)	$2,500/$5,000			
BENEFITS	Services not subject to deductible unless otherwise indicated			
PREVENTIVE CARE				
	Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.			
OUTPATIENT SERVICES (per visit or procedure)				
Primary care/Specialty care office visit	$40 copay/$60 copay		$50 copay/$75 copay	
Ambulatory surgery	40% coinsurance (after deductible)			
Diagnostic lab (in a medical office or contracted free-standing facility)	No charge			
Therapeutic and diagnostic X-ray	40% coinsurance (after deductible)			
INPATIENT HOSPITAL CARE				
Hospital care and professional visits	40% coinsurance (after deductible)			
MATERNITY				
Routine prenatal care visit	No charge			
Delivery and inpatient well-baby care	40% coinsurance (after deductible)			
EMERGENCY AND URGENT CARE				
Emergency room visit	$350 copay		$500 copay	
Nonroutine care	$40 copay		$50 copay	
After-hours care	$100 copay			
Ambulance service	40% coinsurance (up to $500 per trip)			
PRESCRIPTION DRUGS	$2,000 pharmacy deductible for brand drugs			
Pharmacy (up to a 30-day supply filled at a Kaiser Permanente or affiliated pharmacy)[3]	Generic: $15 copay/Brand $30 copay		Not covered	
Mail-order (up to a 90-day supply)[3]	Generic: $30 copay/Brand $60 copay		Not covered	

[1]In deductible plans, the deductible does not apply to the out-of-pocket maximum. In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.

[2]For families in a deductible plan, individual family members are responsible for meeting the family deductible and out-of-pocket maximum only up to the individual deductible and out-of-pocket maximum amount, until the family out-of-pocket maximum is met. For family memberships in an HSA-qualified deductible HMO plan, the individual deductible and out-of-pocket maximum do not apply. The family deductible and out-of-pocket maximum can be met by a combination of family members.

[3]Nonpreferred brand-name drugs are not covered. There is a coinsurance for specialty drugs. Prescribed contraceptives are no charge and are not subject to the deductible. See the *Membership Agreement* for specific details.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

QUESTIONS? Contact your broker today!

How HSA-qualified deductible HMO plans work

An HSA-qualified plan is a deductible plan that is eligible to be paired with an optional health savings account, or HSA. If you sign up for an HSA-qualified plan and open an HSA, you can pay for qualified medical expenses with tax-deductible dollars.[1]

An HSA-qualified plan works much like a traditional deductible plan, except all services (except many preventive services) are subject to the deductible. And in our HSA-qualified plans, once you meet your deductible, you also meet your out-of-pocket maximum, so you don't have to pay a charge for any covered services for the rest of the year.

However, the main difference is that you can save money with HSA-qualified deductible plans. This is because you can pay for qualified medical expenses—even those not covered by your health plan—with tax-deductible dollars. However, qualified expenses not covered by your health plan will not contribute to your deductible or out-of-pocket maximum.

All you have to do is:

- Sign up for an HSA-qualified health plan.
- If you are eligible, open a health savings account.
- Contribute tax-deductible dollars to this account.[2]
- Use those tax-free funds to pay for qualified health care expenses.

What you don't use rolls over to the next year and continues earning interest.[3]

Advantages of opening an HSA

- **Portability.** The money belongs to you, so if you change health plans, you can take your HSA with you.
- **Rollover of unused funds.** There is no "use it or lose it" restriction each year. What you don't use stays in your account until you are ready to use it.[3]
- **Control.** You decide when to put the money in and when to take it out.
- **Retirement savings.** The money in your account can be invested through the institution where you open it. And after age 65, you can use the funds, taxed at your ordinary income rate, for any reason without penalties.
- **Flexibility.** You can use the money in your HSA to pay for qualified medical expenses, even those your deductible plan does not cover.

An HSA offers triple tax advantages

- Tax-deductible contributions to your account
- Tax-free investment earnings
- Tax-free withdrawals when funds are used for qualified medical expenses

[1] Tax references relate to federal income tax only. The tax treatment of health savings account contributions and distributions under state income tax laws differs from the federal tax treatment. Consult with your financial or tax adviser for more information.

[2] For 2013, the federally established maximum contribution for an eligible individual with self-only coverage is $3,250. The annual maximum contribution for an eligible individual with family coverage is $6,450. This annual maximum is indexed annually for inflation. Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser.

[3] Earnings vary depending on the type of investment plan you opt for and/or the HSA provider you choose. Amount earned is based on the investment plan and market value, and in some instances, the account may actually lose money.

QUESTIONS? Contact your broker today!

60097202 Colorado January 2013

Using a health savings account

What are qualified medical expenses?

You can use an HSA to pay for deductibles, copays, coinsurance, and many supplies and services not covered by your health plan. Generally, these are expenses that would qualify for the medical and dental expense deduction on your income tax.

Here are just a few examples of HSA-qualified expenses:

- Eyeglasses and laser eye surgery
- Dental care
- Acupuncture
- Chiropractic services
- Hearing aids

For a complete list, see *Publication 502, Medical and Dental Expenses* at www.irs.gov.

Who's eligible for an HSA?

To be eligible for an HSA, you need to meet the following requirements:

- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not a qualified deductible plan (with certain exceptions).
- You can't have received benefits from the Department of Veterans Affairs in the past three months.

You may set up your HSA through any financial institution that offers these accounts.[1]

Using an HSA-qualified deductible plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

With our HSA-qualified deductible HMO plans, all covered services (other than many preventive care services) are subject to your deductible. On the KP 3500/0/HSA/Rx plan, you would pay the first $3,500 of your medical and pharmacy expenses out of pocket.

In this example, you would pay full charge for the doctor's office visit, the X-ray, and the medication. All your out-of-pocket costs for covered services would be applied to your $3,500 deductible.

Since your deductible contributes to your out-of-pocket maximum in HSA-qualified deductible plans, once you meet your deductible, you also meet your $3,500 out-of-pocket maximum. That means you can receive most covered services for no charge after you meet your deductible.

And, if you opened an HSA, you would be able to pay for these services with tax-free dollars.

Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. For more information on health savings accounts, please visit www.irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

[1]Kaiser Permanente does not provide or administer financial products, including HSAs, and does not offer financial, tax, or investment advice. Members are responsible for their own investment decisions. If a member uses his or her HSA debit card to pay for something other than a qualified medical expense, the expenditure is subject to tax and, for individuals who are not disabled or over 65, a 20 percent tax penalty. Please note that when an HSA provider pays disbursements, it does not monitor whether they are for qualified medical expenses. It is the member's responsibility to determine whether expenses qualify for tax-free reimbursement from his or her HSA.

QUESTIONS? Contact your broker today!

60097202 Colorado January 2013

Benefit highlights

	HSA-QUALIFIED DEDUCTIBLE HMO PLANS		
	KP 3500/0/HSA/Rx	**KP 4500/0/HSA/Rx**	**KP 5500/0/HSA/Rx**
FEATURES	**The deductible contributes to the out-of-pocket maximum.**		
Annual deductible (individual/family)[1,2]	$3,500/$7,000	$4,500/$9,000	$5,500/$11,000
Annual out-of-pocket maximum (individual/family)[2] (includes medical deductible)	$3,500/$7,000	$4,500/$9,000	$5,500/$11,000
BENEFITS	All services except preventive care are subject to deductible		
PREVENTIVE CARE			
	Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.		
OUTPATIENT SERVICES (per visit or procedure)			
Primary care/Specialty care office visit	No charge (after deductible)		
Ambulatory surgery	No charge (after deductible)		
Diagnostic lab (in a medical office or contracted free-standing facility)	No charge (after deductible)		
Therapeutic and diagnostic X-ray	No charge (after deductible)		
INPATIENT HOSPITAL CARE			
Hospital care and professional visits	No charge (after deductible)		
MATERNITY			
Routine prenatal care visit	No charge		
Delivery and inpatient well-baby care	No charge (after deductible)		
EMERGENCY AND URGENT CARE			
Emergency room visit	No charge (after deductible)		
Nonroutine care	No charge (after deductible)		
After-hours care	No charge (after deductible)		
Ambulance service	No charge (after deductible)		
PRESCRIPTION DRUGS			
Pharmacy (up to a 30-day supply filled at a Kaiser Permanente or affiliated pharmacy)[3]	No charge (after medical deductible)		
Mail-order (up to a 90-day supply)[3]	No charge (after medical deductible)		

[1]In deductible plans, the deductible does not apply to the out-of-pocket maximum. In HSA-qualified deductible HMO plans, the deductible does apply to the out-of-pocket maximum.

[2]For families in a deductible plan, individual family members are responsible for meeting the family deductible and out-of-pocket maximum only up to the individual deductible and out-of-pocket maximum amount, until the family out-of-pocket maximum is met. For family memberships in an HSA-qualified deductible HMO plan, the individual deductible and out-of-pocket maximum do not apply. The family deductible and out-of-pocket maximum can be met by a combination of family members.

[3]Prescribed contraceptives are no charge and are not subject to the deductible. See the *Membership Agreement* for specific details.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

QUESTIONS? Contact your broker today!

DENVER/BOULDER

Kaiser Foundation Health Plan of Colorado

IMPORTANT DETAILS AND NOTICES

Kaiser Permanente for Individuals and Families

KAISER PERMANENTE®

ELIGIBILITY REQUIREMENTS

To be eligible for Kaiser Permanente for Individuals and Families, all of the following must be true:

- You live in our service area (see the *2013 Rates* brochure for ZIP codes).
- You have signed a disclosure form declining Business Group of One coverage if you qualify for Business Group of One coverage.
- You pass a required medical review that is a part of the application process.[1] Applicants under the age of 19 are not required to pass medical review. Federal law requires insurers that offer child-only policies to issue them without regard to the child's health status or condition. The state of Colorado has established open enrollment periods for applicants under the age of 19 who are seeking individual health coverage. The open enrollment periods are the months of January and July. If your child has experienced a qualifying event, he or she may enroll outside the open enrollment periods.

You may also cover certain dependents on your account. These include your spouse and your dependent children, including natural children, stepchildren, legally adopted children, and children under permanent court-appointed legal guardianship. Dependent children are eligible for coverage on your family account until they turn 26. Upon reaching age 26, your dependent will need to enroll as a subscriber on his or her own account. An unmarried child medically certified as disabled and dependent upon the parent is covered at any age.

EMPLOYER REIMBURSEMENT RULES

You may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer unless you submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. To see if this applies to you, please answer the following questions:

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

If you answered *Yes*, please continue. If you answered *No*, you may stop because this requirement does not apply to you.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

If the answer to both questions 1 and 2 is *Yes*, you may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer.

If the answer to question 1 is *Yes* and the answer to question 2 is *No*, you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached to your application. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

If you answer *Yes* to both questions 1 and 2, you may apply for individual coverage if you pay the full premium yourself and are not reimbursed in any way by your employer. You may also be eligible for small group health coverage. Please call **1-866-279-0704** for information about small group plans.

[1]If you fail the medical review to qualify for Kaiser Permanente for Individuals and Families, you may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. CoverColorado does not impose pre-existing conditions or limitations on coverage. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. For information about CoverColorado, please contact CoverColorado by mail at 425 South Cherry St., Suite 160, Glendale, CO 80246, or by phone at 303-863-1960. Or visit covercolorado.org.

NOTICES

ARBITRATION

Except for: (1) claims filed in small claims court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians ("respondent(s)"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

CONFIDENTIALITY PRACTICES

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws. We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement through the use of measurement data, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us, and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our *Notice of Privacy Practices*, which is on our website, and in our medical offices, or by calling Member Services. If you have questions or concerns about our privacy practices, please contact Member Services at **303-338-3800**.

NOT FEDERALLY QUALIFIED

Kaiser Permanente for Individuals and Families plans are not federally qualified health plans.

SYNOPSIS ONLY

This is a synopsis of coverage, effective January 1, 2013, for eligible members that only briefly summarizes the major provisions of the *Agreement* between Kaiser Permanente and you. There are services or conditions that are excluded from coverage or that may only be covered under certain circumstances. Further information may be obtained by contacting Kaiser Permanente at **1-800-634-4579** or by referring to your *Membership Agreement*. In the event of ambiguity and/or conflict between this synopsis and/or the *Membership Agreement*, the *Membership Agreement* shall control.

UTILIZATION MANAGEMENT PROCESSES

Kaiser Permanente's Utilization Management Program uses the advice and cooperation of practitioners and providers to help achieve quality care that is a good value for our members. Requests for authorization of care (preservice, concurrent, and retrospective) are reviewed for specific plan benefits, current eligibility, and medical appropriateness of hospital and outpatient services in order to determine a member's eligibility for coverage. In determining whether requests for authorization of care will be covered, nationally developed criteria, which have been reviewed and approved by Kaiser Permanente physicians, are applied along with medical expert opinion when necessary.

INFORMATION FOR BUSINESS GROUPS OF ONE

If you are a Business Group of One, you have a choice about the type of plan in which you enroll. You may select a plan for individuals and families as described in this enrollment kit, or you may choose to enroll in a small group plan. In accordance with State of Colorado insurance regulations, this brochure contains the *Health Benefit Plan Description Form* for the Kaiser Permanente Small Group HMO Basic Limited Mandate Health Benefit Plan and the Kaiser Permanente Small Group HMO Standard Health Benefit Plan.

If you choose to apply for a plan through Kaiser Permanente for Individuals and Families, please be sure to complete the *Business Group of One Determination Form* and the *Business Group of One Disclosure Form* as part of the application process.

The small group plans on the following pages are guarantee-issued plans for Business Group of One applicants. Please call **1-866-279-0704** if you are interested in Business Group of One small group plan options.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Basic Limited Mandate Health Benefit Plan for Colorado
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: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, 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]	Calendar
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 a) $1,500 b) $4,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $10,000/Individual b) $20,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No 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 the Deductible; Applies toward OPM a) $40 Copayment each primary care office visit b) $60 Copayment each specialist office visit
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Not subject to the Deductible; Applies toward OPM a) $40 Copayment each visit b) $40 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.

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]**	Applies toward OPM a) Applicable Copayments for each type of service b) $1,000 Copayment per day up to $4,000 per admission (not subject to Deductible)
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	$150 annual Pharmacy Deductible per person, Does not apply toward OPM $20 Copayment – preferred generic, $50 Copayment – preferred brand-name, or $70 Copayment – non-preferred up to a 30-day supply. Mail-order drugs filled for up to a 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact your Clinical Pharmacy Call Center at **303-338-4503** or toll free at **1-866-244-4119** or TTY **1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $1,000 Copayment per day up to $4,000 per admission
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $500 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**	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment b) MRI/CT/PET – 30% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[7], [8]	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 30% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $100 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Not Covered
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for acute detox: maximum 5 days per episode and 2 episodes per lifetime

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Not subject to the Deductible; Applies toward OPM $40 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT	Subject to the Deductible; Applies toward OPM 30% Coinsurance (20% for prosthetic devices for arms or legs)
23. OXYGEN	Subject to the Deductible; Applies toward OPM 30% Coinsurance
24. ORGAN TRANSPLANTS	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants are limited to liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE	Subject to Deductible; Applies toward OPM 30% Copayment each visit. Limited to 60 visits per year.
26. HOSPICE CARE	Subject to Deductible; Applies toward OPM 30% Copayment
27. SKILLED NURSING FACILITY CARE	Subject to the Deductible; Applies toward OPM 30% Copayment per day up to 100 days per year for prescribed skilled nursing services at skilled nursing facilities approved by Kaiser Permanente
28. DENTAL CARE	Not covered except for accidental injuries. Additional coverage available as a separate dental care plan or as an optional benefit
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	Not Covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **(1) Spinal manipulation**	None

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
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. A list of exclusions is available immediately upon request from your carrier

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 80014-1622 **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 SG-BSEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13) Small Group
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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Standard Health Benefit Plan for Colorado
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 and Urgent Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, 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[3]	Calendar
4a. ANNUAL DEDUCTIBLE[3a] *(Deductibles do not apply to benefits with flat dollar copays.)* **a) Individual[3b]** **b) Family[3c]** (Aggregate deductibles.)	a) $500 b) $1,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[4] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $4,500/Individual b) $9,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No 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[5] **a) Primary Care Providers** **b) Specialists**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each primary care office visit b) $50 Copayment each specialist office visit

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
9. PREVENTIVE CARE[5a, 5b] **a) Children's services** **b) Adults' services** **c) Colorectal screening services**[5c] **d) State mandated preventive services**[5a,, 5b]	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each visit b) $30 Copayment each visit c) 100% d) $30 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.
10. MATERNITY[6] **a) Prenatal care** **b) Delivery & inpatient well baby care**	Applicable Copayments for each type of service[7]
11. PRESCRIPTION DRUGS[8, 9] Level of coverage and restrictions on prescriptions. *(Copays do not apply to out-of-pocket maximums.)*	Not subject to the Deductible; Does not apply toward OPM $15 Copayment – preferred generic, $40 Copayment – preferred brand-name, or $60 Copayment – non-preferred up to a 30-day supply. Mail order drugs filled for up to a 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact your Clinical Pharmacy Call Center at **303-338-4503** or toll free at **1-866-244-4119** or TTY **1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $500 Copayment per day up to $2,000 per admission[10]
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit for outpatient surgery performed in any setting other than inpatient[10a]
14. DIAGNOSTICS[11] **a) Laboratory & X-ray** **b) MRI, Nuclear Medicine and Other High Tech Services**[11a]	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment for physician-ordered services b) MRI/CT/PET – 20% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[12, 13]	Not subject to the Deductible; Applies toward OPM $150 Copayment each visit[14] at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 20% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $75 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS[15] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness

19. OTHER MENTAL HEALTH CARE[16] **a) Inpatient care[17]** **b) Outpatient care**	Applies toward OPM a) Inpatient - 20% Copayment. Limited to 45 inpatient or 90 partial days per year (Subject to the Deductible) b) Outpatient - $50 Copayment for up to 20 visits per year (Not subject to the Deductible)

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for diagnosis, medical treatment and referral services only[19]
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY[20]	Not subject to the Deductible; Applies toward OPM $30 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT[21]	Subject to the Deductible; Applies toward OPM 20% Copayment
23. OXYGEN	Subject to the Deductible; Applies toward OPM 20% Copayment
24. ORGAN TRANSPLANTS[22]	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE[22a]	Subject to the Deductible; Applies toward OPM 20% Copayment
26. HOSPICE CARE[23]	Subject to the Deductible; Applies toward OPM 20% Copayment
27. SKILLED NURSING FACILITY CARE[24]	Subject to the Deductible; Applies toward OPM 20% Copayment per day up to 100 days per year
28. DENTAL CARE	Not covered except for dental care needed as a result of an accident. [5b, 24a]
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	No [See line 31(a)]
31. SIGNIFICANT ADDITIONAL COVERED	Not subject to the Deductible; Applies toward OPM

SERVICES (list up to 5) **a) Spinal manipulation** **b) Hearing Aids**[24b]	a) $30 Copayment each visit b) Benefit level determined by place of service

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[25, 25b]	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"?[25b]	Not Applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[24a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids[25a] and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.

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? [27]	Member Services 2500 South Havana Street Aurora, CO 80014-1622 **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?	Contact: Colorado Division of Insurance Consumer Affairs Section 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7490 Toll-free (in state) 800-930-3745 Email: Insurance@dora.state.co.us

	Fax: 303-948-7455

PART D: USING THE PLAN

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
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.	This is a small group plan. SG-STEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13)
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 the 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 may pay 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] Out-of network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply. **(Endnote applies to Standard Preferred Provider Plan only.)**

[3] "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).

[3a] "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 should be noted in boxes 8 through 31.

[3b] "Individual" means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.

[3c] "Family" is the maximum deductible amount that is required to be met for all family members covered on an aggregate basis.

[4] "Out-of-pocket maximum" refers to the maximum amount you will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. The copays for other than prescription drugs are applied to the out-of-pocket maximum on the HMO plan only.

[5] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections or injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

[5a] As of January 1, 2010 includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B": recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 of Colorado Insurance Regulation 4-6-5 for the list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24. For the standard HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

[5b] The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of Colorado Insurance Regulation 4-6-5. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network): These services can be subject to the plan's out-of-network cost-sharing requirements.

[5c] Benefits provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

[6] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[7] The hospital copay applies to mother and well baby together; there are not separate copayments.

[8] Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders as required by §10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold group health plan in Colorado. Coverage levels for injectable drugs are based on the place of service (office: included under the office visit copay; pharmacy: covered at appropriate copay based on drug type).

[9] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand-name, or non-preferred. Additionally, as noted above in footnote 4, prescription drug benefits are not subject to the deductible and the copayments are not applied to the out-of-pocket maximums.

[10] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10a] Copay includes all physician, facility services and supplies delivered during the visit.

[11] Includes low dose mammography screening as mandated by Colorado law, §10-16-104(18)(b)(III), C.R.S. Diagnostic services do not include therapeutic treatment.

[11a] Covered procedures are: MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans.

[12] "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.

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

[14] Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount you pay shall not exceed 50% of the charge for any single office visit.

[16] Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

[17] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

[18] Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S. **(Endnote applies to Standard Indemnity Plan and Standard Preferred Provider Plan only.)**

[19] Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

[20] Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

[21] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is

covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[23] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.

[24] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

[24a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

[24b] Hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits are provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.

[25] "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.

[25a] Only hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S.

[25b] Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

[26] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[27] Grievances. Colorado law requires all plans to use consistent grievance procedures. Contact 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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

Kaiser Permanente for Individuals and Families

kp.org

60095003 Denver/Boulder January 2013

KAISER PERMANENTE®

SOUTHERN COLORADO

Kaiser Foundation Health Plan of Colorado

IMPORTANT DETAILS AND NOTICES

Kaiser Permanente for Individuals and Families

KAISER PERMANENTE®

ELIGIBILITY REQUIREMENTS

To be eligible for Kaiser Permanente for Individuals and Families, all of the following must be true:

- You live in our service area (see the *2013 Rates* brochure for ZIP codes).
- You have signed a disclosure form declining Business Group of One coverage if you qualify for Business Group of One coverage.
- You pass a required medical review that is a part of the application process.[1] Applicants under the age of 19 are not required to pass medical review. Federal law requires insurers that offer child-only policies to issue them without regard to the child's health status or condition. The state of Colorado has established open enrollment periods for applicants under the age of 19 who are seeking individual health coverage. The open enrollment periods are the months of January and July. If your child has experienced a qualifying event, he or she may enroll outside the open enrollment periods.

You may also cover certain dependents on your account. These include your spouse and your dependent children, including natural children, stepchildren, legally adopted children, and children under permanent court-appointed legal guardianship. Dependent children are eligible for coverage on your family account until they turn 26. Upon reaching age 26, your dependent will need to enroll as a subscriber on his or her own account. An unmarried child medically certified as disabled and dependent upon the parent is covered at any age.

EMPLOYER REIMBURSEMENT RULES

You may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer unless you submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. To see if this applies to you, please answer the following questions:

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

If you answered *Yes*, please continue. If you answered *No*, you may stop because this requirement does not apply to you.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

If the answer to both questions 1 and 2 is *Yes*, you may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer.

If the answer to question 1 is *Yes* and the answer to question 2 is *No*, you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached to your application. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

If you answer *Yes* to both questions 1 and 2, you may apply for individual coverage if you pay the full premium yourself and are not reimbursed in any way by your employer. You may also be eligible for small group health coverage. Please call toll free **1-866-279-0704** for information about small group plans.

[1]If you fail the medical review to qualify for Kaiser Permanente for Individuals and Families, you may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. CoverColorado does not impose pre-existing conditions or limitations on coverage. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. For information about CoverColorado, please contact CoverColorado by mail at 425 South Cherry St., Suite 160, Glendale, CO 80246, or by phone at 303-863-1960. Or visit covercolorado.org.

NOTICES

ARBITRATION

Except for: (1) claims filed in small claims court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians ("respondent(s)"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

CONFIDENTIALITY PRACTICES

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws. We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement through the use of measurement data, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us, and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our *Notice of Privacy Practices*, which is on our website, and in our medical offices, or by calling Member Services. If you have questions or concerns about our privacy practices, please contact Member Services at **303-338-3800**.

NOT FEDERALLY QUALIFIED

Kaiser Permanente for Individuals and Families plans are not federally qualified health plans.

SYNOPSIS ONLY

This is a synopsis of coverage, effective January 1, 2013, for eligible members that only briefly summarizes the major provisions of the *Agreement* between Kaiser Permanente and you. There are services or conditions that are excluded from coverage or that may only be covered under certain circumstances. Further information may be obtained by contacting Kaiser Permanente at **1-800-634-4579** or by referring to your *Membership Agreement*. In the event of ambiguity and/or conflict between this synopsis and/or the *Membership Agreement*, the *Membership Agreement* shall control.

UTILIZATION MANAGEMENT PROCESSES

Kaiser Permanente's Utilization Management Program uses the advice and cooperation of practitioners and providers to help achieve quality care that is a good value for our members. Requests for authorization of care (preservice, concurrent, and retrospective) are reviewed for specific plan benefits, current eligibility, and medical appropriateness of hospital and outpatient services in order to determine a member's eligibility for coverage. In determining whether requests for authorization of care will be covered, nationally developed criteria, which have been reviewed and approved by Kaiser Permanente physicians, are applied along with medical expert opinion when necessary.

INFORMATION FOR BUSINESS GROUPS OF ONE

If you are a Business Group of One, you have a choice about the type of plan in which you enroll. You may select a plan for individuals and families as described in this enrollment kit, or you may choose to enroll in a small group plan. In accordance with State of Colorado insurance regulations, this brochure contains the *Health Benefit Plan Description Form* for the Kaiser Permanente Small Group HMO Basic Limited Mandate Health Benefit Plan and the Kaiser Permanente Small Group HMO Standard Health Benefit Plan.

If you choose to apply for a plan through Kaiser Permanente for Individuals and Families, please be sure to complete the *Business Group of One Determination Form* and the *Business Group of One Disclosure Form* as part of the application process.

The small group plans on the following pages are guarantee-issued plans for Business Group of One applicants. Please call toll free **1-866-279-0704** if you are interested in Business Group of One small group plan options.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Basic Limited Mandate Health Benefit Plan for Colorado
Southern Colorado

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: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller 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]	Calendar
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 a) $1,500 b) $4,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $10,000/Individual b) $20,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum
7A. COVERED PROVIDERS	Kaiser Permanente Southern Colorado Plan Providers. 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 the Deductible; Applies toward OPM a) $40 Copayment each primary care office visit b) $60 Copayment each specialist office visit
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Not subject to the Deductible; Applies toward OPM a) $40 Copayment each visit b) $40 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.

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]	Applies toward OPM a) Applicable Copayments for each type of service b) $1,000 Copayment per day up to $4,000 per admission (Not subject to the Deductible)
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	$150 annual Pharmacy Deductible per person, Does not apply toward OPM $20 Copayment – preferred generic, $50 Copayment – preferred brand-name, or $70 Copayment – non-preferred up to a 30-day supply. Mail order drugs filled for up to a 60 or 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact Southern Colorado Member Services toll-free at **1-888-681-7878** or TTY **1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $1,000 Copayment per day up to $4,000 per admission
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $500 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**	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment b) MRI/CT/PET – 30% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[7], [8]	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 30% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $100 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Not Covered
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for acute detox: maximum 5 days per episode and 2 episodes per lifetime

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Not subject to the Deductible; Applies toward OPM $40 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT	Subject to the Deductible; Applies toward OPM 30% Coinsurance (20% for prosthetic devices for arms or legs)
23. OXYGEN	Subject to the Deductible; Applies toward OPM 30% Coinsurance
24. ORGAN TRANSPLANTS	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants are limited to liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE	Subject to the Deductible; Applies toward OPM 30% Copayment each visit. Limited to 60 visits per year.
26. HOSPICE CARE	Subject to the Deductible; Applies toward OPM 30% Copayment
27. SKILLED NURSING FACILITY CARE	Subject to the Deductible; Applies toward OPM 30% Copayment per day up to 100 days per year for prescribed skilled nursing services at skilled nursing facilities approved by Kaiser Permanente
28. DENTAL CARE	Not covered except for accidental injuries. Additional coverage available as a separate dental care plan or as an optional benefit
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	Not Covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **(1) Spinal manipulation**	None

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
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. A list of exclusions is available immediately upon request from your carrier

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 toll-free at **1-888-681-7878** 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 80014-1622 Toll-free **1-888-681-7878** 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 SG-BSEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13) Small Group
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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Standard Health Benefit Plan for Colorado
Southern Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)

2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency and Urgent Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller 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[3]	Calendar
4a. ANNUAL DEDUCTIBLE[3a] *(Deductibles do not apply to benefits with flat dollar copays.)* **a) Individual[3b]** **b) Family[3c]** (Aggregate deductibles.)	 a) $500 b) $1,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[4] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $4,500/Individual b) $9,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum
7A. COVERED PROVIDERS	Kaiser Permanente Southern Colorado Plan Providers 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[5] **a) Primary Care Providers** **b) Specialists**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each primary care office visit b) $50 Copayment each specialist office visit

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
9. PREVENTIVE CARE[5a, 5b] **a) Children's services** **b) Adults' services** **c) Colorectal screening services**[5c] **d) State mandated preventive services**[5a,, 5b]	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each visit b) $30 Copayment each visit c) 100% d) $30 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.
10. MATERNITY[6] **a) Prenatal care** **b) Delivery & inpatient well baby care**	Applicable Copayments for each type of service[7]
11. PRESCRIPTION DRUGS[8, 9] Level of coverage and restrictions on prescriptions. *(Copays do not apply to out-of-pocket maximums.)*	Not subject to the Deductible; Does not apply toward OPM $15 Copayment – preferred generic, $40 Copayment – preferred brand-name, or $60 Copayment – non-preferred up to a 30-day supply. Mail order drugs filled for up to a 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact Southern Colorado Member Services toll-free at **1-888-681-7878**or TTY **1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $500 Copayment per day up to $2,000 per admission[10]
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit for outpatient surgery performed in any setting other than inpatient[10a]
14. DIAGNOSTICS[11] **a) Laboratory & X-ray** **b) MRI, Nuclear Medicine and Other High Tech Services**[11a]	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment for physician-ordered services b) MRI/CT/PET – 20% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[12, 13]	Not subject to the Deductible; Applies toward OPM $150 Copayment each visit[14] at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 20% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $75 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS[15] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE[16] **a) Inpatient care**[17] **b) Outpatient care**	Applies toward OPM a) Inpatient - 20% Copayment. Limited to 45 inpatient or 90 partial days per year (Subject to the Deductible) b) Outpatient - $50 Copayment for up to 20 visits per year (Not subject to the Deductible)

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for diagnosis, medical treatment and referral services only[19]
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY[20]	Not subject to the Deductible; Applies toward OPM $30 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT[21]	Subject to the Deductible; Applies toward OPM 20% Copayment
23. OXYGEN	Subject to the Deductible; Applies toward OPM 20% Copayment
24. ORGAN TRANSPLANTS[22]	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE[22a]	Subject to the Deductible; Applies toward OPM 20% Copayment
26. HOSPICE CARE[23]	Subject to the Deductible; Applies toward OPM 20% Copayment
27. SKILLED NURSING FACILITY CARE[24]	Subject to the Deductible; Applies toward OPM 20% Copayment per day up to 100 days per year
28. DENTAL CARE	Not covered except for dental care needed as a result of an accident.[5b, 24a]
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	No [See line 31(a)]
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **a) Spinal manipulation** **b) Hearing Aids[24b]**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each visit b) Benefit level determined by place of service

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[25, 25b]	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"?[25b]	Not Applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[24a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids[25a] and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.

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 toll-free at **1-888-681-7878** or TTY **1-800-521-4874**
40. Whom do I write/call if I have a complaint or want to file a grievance? [27]	Member Services 2500 South Havana Street Aurora, CO 80014-1622 Toll-free **1-888-681-7878** or TTY **1-800-521-4874**
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Contact: Colorado Division of Insurance Consumer Affairs Section 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7490 Toll-free (in state) 800-930-3745 Email: Insurance@dora.state.co.us Fax: 303-948-7455

PART D: USING THE PLAN

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
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.	This is a small group plan. SG-STEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13)
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 the 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 may pay 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] Out-of network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply. **(Endnote applies to Standard Preferred Provider Plan only.)**

[3] "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).

[3a] "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 should be noted in boxes 8 through 31.

[3b] "Individual" means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.

[3c] "Family" is the maximum deductible amount that is required to be met for all family members covered on an aggregate basis.

[4] "Out-of-pocket maximum" refers to the maximum amount you will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. The copays for other than prescription drugs are applied to the out-of-pocket maximum on the HMO plan only.

[5] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections or injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

[5a] As of January 1, 2010 includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B": recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 of Colorado Insurance Regulation 4-6-5 for the list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24. For the standard HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

[5b] The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of Colorado Insurance Regulation 4-6-5. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network): These services can be subject to the plan's out-of-network cost-sharing requirements.

[5c] Benefits provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of

cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

[6] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[7] The hospital copay applies to mother and well baby together; there are not separate copayments.

[8] Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders as required by §10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold group health plan in Colorado. Coverage levels for injectable drugs are based on the place of service (office: included under the office visit copay; pharmacy: covered at appropriate copay based on drug type).

[9] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand-name, or non-preferred. Additionally, as noted above in footnote 4, prescription drug benefits are not subject to the deductible and the copayments are not applied to the out-of-pocket maximums.

[10] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10a] Copay includes all physician, facility services and supplies delivered during the visit.

[11] Includes low dose mammography screening as mandated by Colorado law, §10-16-104(18)(b)(III), C.R.S. Diagnostic services do not include therapeutic treatment.

[11a] Covered procedures are: MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans.

[12] "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.

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

[14] Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount you pay shall not exceed 50% of the charge for any single office visit.

[16] Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

[17] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

[18] Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S. **(Endnote applies to Standard Indemnity Plan and Standard Preferred Provider Plan only.)**

[19] Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

[20] Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

[21] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[23] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.

[24] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

[24a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

[24b] Hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits are provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.

[25] "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.

[25a] Only hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S.

[25b] Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

[26] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[27] Grievances. Colorado law requires all plans to use consistent grievance procedures. Contact 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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

Kaiser Permanente for Individuals and Families

kp.org

60096001 Southern Colorado January 2013

KAISER PERMANENTE®

NORTHERN COLORADO

Kaiser Foundation Health Plan of Colorado

IMPORTANT DETAILS AND NOTICES

Kaiser Permanente for Individuals and Families

KAISER PERMANENTE®

ELIGIBILITY REQUIREMENTS

To be eligible for Kaiser Permanente for Individuals and Families, all of the following must be true:

- You live in our service area (see the *2013 Rates* brochure for ZIP codes).
- You have signed a disclosure form declining Business Group of One coverage if you qualify for Business Group of One coverage.
- You pass a required medical review that is a part of the application process.[1] Applicants under the age of 19 are not required to pass medical review. Federal law requires insurers that offer child-only policies to issue them without regard to the child's health status or condition. The state of Colorado has established open enrollment periods for applicants under the age of 19 who are seeking individual health coverage. The open enrollment periods are the months of January and July. If your child has experienced a qualifying event, he or she may enroll outside the open enrollment periods.

You may also cover certain dependents on your account. These include your spouse and your dependent children, including natural children, stepchildren, legally adopted children, and children under permanent court-appointed legal guardianship. Dependent children are eligible for coverage on your family account until they turn 26. Upon reaching age 26, your dependent will need to enroll as a subscriber on his or her own account. An unmarried child medically certified as disabled and dependent upon the parent is covered at any age.

EMPLOYER REIMBURSEMENT RULES

You may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer unless you submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. To see if this applies to you, please answer the following questions:

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

If you answered *Yes*, please continue. If you answered *No*, you may stop because this requirement does not apply to you.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

If the answer to both questions 1 and 2 is *Yes*, you may not be issued an individual policy with the premiums, or a portion thereof, paid or reimbursed by an employer.

If the answer to question 1 is *Yes* and the answer to question 2 is *No*, you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached to your application. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

If you answer *Yes* to both questions 1 and 2, you may apply for individual coverage if you pay the full premium yourself and are not reimbursed in any way by your employer. You may also be eligible for small group health coverage. Please call **1-866-279-0704** for information about small group plans.

[1]If you fail the medical review to qualify for Kaiser Permanente for Individuals and Families, you may be eligible to participate in CoverColorado, a state-sponsored guaranteed-issue health care coverage program. CoverColorado does not impose pre-existing conditions or limitations on coverage. In addition, Colorado has designated CoverColorado as the state alternative mechanism for health coverage of HIPAA (the Health Insurance Portability and Accountability Act of 1996) eligibles in accordance with federal law. You may be eligible for CoverColorado if you have a total of at least 18 months of creditable health coverage without a break in coverage of more than 62 days at any time (including now) and your most recent creditable coverage was under a group health plan. For information about CoverColorado, please contact CoverColorado by mail at 425 South Cherry St., Suite 160, Glendale, CO 80246, or by phone at 303-863-1960. Or visit covercolorado.org.

NOTICES

ARBITRATION

Except for: (1) claims filed in small claims court; (2) claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan providers or affiliated physicians ("respondent(s)"), which arise from any alleged failure or violation, including but not limited to any duty relating to or incident to the *Evidence of Coverage* or the *Medical and Hospital Services Agreement*, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

CONFIDENTIALITY PRACTICES

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws. We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement through the use of measurement data, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us, and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our *Notice of Privacy Practices*, which is on our website, and in our medical offices, or by calling Member Services. If you have questions or concerns about our privacy practices, please contact Member Services at **303-338-3800**.

NOT FEDERALLY QUALIFIED

Kaiser Permanente for Individuals and Families plans are not federally qualified health plans.

SYNOPSIS ONLY

This is a synopsis of coverage, effective January 1, 2013, for eligible members that only briefly summarizes the major provisions of the *Agreement* between Kaiser Permanente and you. There are services or conditions that are excluded from coverage or that may only be covered under certain circumstances. Further information may be obtained by contacting Kaiser Permanente at **1-800-634-4579** or by referring to your *Membership Agreement*. In the event of ambiguity and/or conflict between this synopsis and/or the *Membership Agreement*, the *Membership Agreement* shall control.

UTILIZATION MANAGEMENT PROCESSES

Kaiser Permanente's Utilization Management Program uses the advice and cooperation of practitioners and providers to help achieve quality care that is a good value for our members. Requests for authorization of care (preservice, concurrent, and retrospective) are reviewed for specific plan benefits, current eligibility, and medical appropriateness of hospital and outpatient services in order to determine a member's eligibility for coverage. In determining whether requests for authorization of care will be covered, nationally developed criteria, which have been reviewed and approved by Kaiser Permanente physicians, are applied along with medical expert opinion when necessary.

INFORMATION FOR BUSINESS GROUPS OF ONE

If you are a Business Group of One, you have a choice about the type of plan in which you enroll. You may select a plan for individuals and families as described in this enrollment kit, or you may choose to enroll in a small group plan. In accordance with State of Colorado insurance regulations, this brochure contains the *Health Benefit Plan Description Form* for the Kaiser Permanente Small Group HMO Basic Limited Mandate Health Benefit Plan and the Kaiser Permanente Small Group HMO Standard Health Benefit Plan.

If you choose to apply for a plan through Kaiser Permanente for Individuals and Families, please be sure to complete the *Business Group of One Determination Form* and the *Business Group of One Disclosure Form* as part of the application process.

The small group plans on the following pages are guarantee-issued plans for Business Group of One applicants. Please call toll free **1-866-279-0704** if you are interested in Business Group of One small group plan options.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Basic Limited Mandate Health Benefit Plan for Colorado
Northern Colorado

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: Larimer, Weld, Morgan, and Adams 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]	Calendar
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 a) $1,500 b) $4,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $10,000/Individual b) $20,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No 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 the Deductible; Applies toward OPM a) $40 Copayment each primary care office visit b) $60 Copayment each specialist office visit
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Not subject to the Deductible; Applies toward OPM a) $40 Copayment each visit b) $40 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.

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]**	Applies toward OPM a) Applicable Copayments for each type of service b) $1,000 Copayment per day up to $4,000 per admission (not subject to Deductible)
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	$150 annual Pharmacy Deductible per person, Does not apply toward OPM $20 Copayment – preferred generic, $50 Copayment – preferred brand-name, or $70 Copayment – non-preferred up to a 30-day supply. Mail-order drugs filled for up to a 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact Northern Colorado Member Services toll-free at **1-800-632-9700** or **TTY 1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $1,000 Copayment per day up to $4,000 per admission
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $500 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**	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment b) MRI/CT/PET – 30% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[7], [8]	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 30% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $100 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Not Covered
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for acute detox: maximum 5 days per episode and 2 episodes per lifetime

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Not subject to the Deductible; Applies toward OPM $40 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT	Subject to the Deductible; Applies toward OPM 30% Coinsurance (20% for prosthetic devices for arms or legs)
23. OXYGEN	Subject to the Deductible; Applies toward OPM 30% Coinsurance
24. ORGAN TRANSPLANTS	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants are limited to liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE	Subject to Deductible; Applies toward OPM 30% Copayment each visit. Limited to 60 visits per year.
26. HOSPICE CARE	Subject to Deductible; Applies toward OPM 30% Copayment
27. SKILLED NURSING FACILITY CARE	Subject to the Deductible; Applies toward OPM 30% Copayment per day up to 100 days per year for prescribed skilled nursing services at skilled nursing facilities approved by Kaiser Permanente
28. DENTAL CARE	Not covered except for accidental injuries. Additional coverage available as a separate dental care plan or as an optional benefit
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	Not Covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **(1) Spinal manipulation**	None

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
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. A list of exclusions is available immediately upon request from your carrier

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 80014-1622 **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 SG-BSEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13) Small Group
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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

KAISER PERMANENTE®

2013 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Small Group HMO Standard Health Benefit Plan for Colorado
Northern Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)

2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency and Urgent Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Larimer, Weld, Morgan, and Adams 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[3]	Calendar
4a. ANNUAL DEDUCTIBLE[3a] *(Deductibles do not apply to benefits with flat dollar copays.)* **a) Individual[3b]** **b) Family[3c]** (Aggregate deductibles.)	 a) $500 b) $1,500
5. OUT-OF-POCKET ANNUAL MAXIMUM[4] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	("OPM") a) $4,500/Individual b) $9,000/Family c) Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No 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[5] **a) Primary Care Providers** **b) Specialists**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each primary care office visit b) $50 Copayment each specialist office visit

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
9. PREVENTIVE CARE[5a, 5b] **a) Children's services** **b) Adults' services** **c) Colorectal screening services[5c]** **d) State mandated preventive services[5a,, 5b]**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each visit b) $30 Copayment each visit c) 100% d) $30 Copayment each visit Certain services are not subject to any cost-sharing requirements. Women's preventive services are 100% covered.
10. MATERNITY[6] **a) Prenatal care** **b) Delivery & inpatient well baby care**	Applicable Copayments for each type of service[7]
11. PRESCRIPTION DRUGS[8, 9] Level of coverage and restrictions on prescriptions. *(Copays do not apply to out-of-pocket maximums.)*	Not subject to the Deductible; Does not apply toward OPM $15 Copayment – preferred generic, $40 Copayment – preferred brand-name, or $60 Copayment – non-preferred up to a 30-day supply. Mail order drugs filled for up to a 90-day supply at two Copayments. Deductible and copays do not apply to prescription contraceptive drugs. For drugs on our approved list, please contact Northern Colorado Member Services toll-free at **1-800-632-9700** or **TTY 1-800-521-4874**.
12. INPATIENT HOSPITAL	Not subject to the Deductible; Applies toward OPM $500 Copayment per day up to $2,000 per admission[10]
13. OUTPATIENT/AMBULATORY SURGERY	Not subject to the Deductible; Applies toward OPM $250 Copayment each visit for outpatient surgery performed in any setting other than inpatient[10a]
14. DIAGNOSTICS[11] **a) Laboratory & X-ray** **b) MRI, Nuclear Medicine and Other High Tech Services[11a]**	Applies toward OPM a) Diagnostic Lab and X-ray, including Therapeutic – No Copayment for physician-ordered services b) MRI/CT/PET – 20% Copayment (Subject to the Deductible)
15. EMERGENCY CARE[12, 13]	Not subject to the Deductible; Applies toward OPM $150 Copayment each visit[14] at a Kaiser Permanente designated Plan or non-Plan emergency room
16. AMBULANCE	Subject to the Deductible; Applies toward OPM 20% Copayment
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	Not subject to the Deductible; Applies toward OPM $75 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS[15] CARE	Coverage is no less extensive than the coverage provided for any other physical illness
19. OTHER MENTAL HEALTH CARE[16] **a) Inpatient care[17]** **b) Outpatient care**	Applies toward OPM a) Inpatient - 20% Copayment. Limited to 45 inpatient or 90 partial days per year (Subject to the Deductible) b) Outpatient - $50 Copayment for up to 20 visits per year (Not subject to the Deductible)

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
20. ALCOHOL & SUBSTANCE ABUSE	Subject to the Deductible; Applies toward OPM 50% Copayment for diagnosis, medical treatment and referral services only[19]
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY[20]	Not subject to the Deductible; Applies toward OPM $30 Copayment each visit up to 20 visits per therapy (physical, speech and occupational therapy) per year Limited to medically necessary therapeutic treatment Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services. For children under the age of 19, the services for the treatment for autism spectrum disorders exceed the benefit limits if such therapy is medically necessary.
22. DURABLE MEDICAL EQUIPMENT[21]	Subject to the Deductible; Applies toward OPM 20% Copayment
23. OXYGEN	Subject to the Deductible; Applies toward OPM 20% Copayment
24. ORGAN TRANSPLANTS[22]	Coverage is no less extensive than the coverage for any other physical illness. Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.
25. HOME HEALTH CARE[22a]	Subject to the Deductible; Applies toward OPM 20% Copayment
26. HOSPICE CARE[23]	Subject to the Deductible; Applies toward OPM 20% Copayment
27. SKILLED NURSING FACILITY CARE[24]	Subject to the Deductible; Applies toward OPM 20% Copayment per day up to 100 days per year
28. DENTAL CARE	Not covered except for dental care needed as a result of an accident. [5b, 24a]
29. VISION CARE	Excluded
30. CHIROPRACTIC CARE	No [See line 31(a)]
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **a) Spinal manipulation** **b) Hearing Aids[24b]**	Not subject to the Deductible; Applies toward OPM a) $30 Copayment each visit b) Benefit level determined by place of service

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[25, 25b]	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"?[25b]	Not Applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[24a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids[25a] and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.

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? [27]	Member Services 2500 South Havana Street Aurora, CO 80014-1622 **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?	Contact: Colorado Division of Insurance Consumer Affairs Section 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7490 Toll-free (in state) 800-930-3745 Email: Insurance@dora.state.co.us Fax: 303-948-7455

PART D: USING THE PLAN

	IN-NETWORK ONLY

	(Out-of-Network care is not covered except as noted)
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.	This is a small group plan. SG-STEOC-DENCOS(01-13) and GA-Small-DENCOS(01-13)
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 the 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 may pay 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] Out-of network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply. **(Endnote applies to Standard Preferred Provider Plan only.)**

[3] "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).

[3a] "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 should be noted in boxes 8 through 31.

[3b] "Individual" means the deductible amount you and each individual covered will have to pay for allowable covered expenses before the carrier will cover those expenses.

[3c] "Family" is the maximum deductible amount that is required to be met for all family members covered on an aggregate basis.

[4] "Out-of-pocket maximum" refers to the maximum amount you will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. The copays for other than prescription drugs are applied to the out-of-pocket maximum on the HMO plan only.

[5] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections or injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

[5a] As of January 1, 2010 includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B": recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 of Colorado Insurance Regulation 4-6-5 for the list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24. For the standard HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

[5b] The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of Colorado Insurance Regulation 4-6-5. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network): These services can be subject to the plan's out-of-network cost-sharing requirements.

[5c] Benefits provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

[6] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[7] The hospital copay applies to mother and well baby together; there are not separate copayments.

[8] Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders as required by §10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold group health plan in Colorado. Coverage levels for injectable drugs are based on the place of service (office: included under the office visit copay; pharmacy: covered at appropriate copay based on drug type).

[9] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand-name, or non-preferred. Additionally, as noted above in footnote 4, prescription drug benefits are not subject to the deductible and the copayments are not applied to the out-of-pocket maximums.

[10] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10a] Copay includes all physician, facility services and supplies delivered during the visit.

[11] Includes low dose mammography screening as mandated by Colorado law, §10-16-104(18)(b)(III), C.R.S. Diagnostic services do not include therapeutic treatment.

[11a] Covered procedures are: MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans.

[12] "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.

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

[14] Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount you pay shall not exceed 50% of the charge for any single office visit.

[16] Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

[17] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

[18] Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S. **(Endnote applies to Standard Indemnity Plan and Standard Preferred Provider Plan only.)**

[19] Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

[20] Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

[21] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[23] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.

[24] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

[24a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

[24b] Hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits are provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.

[25] "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.

[25a] Only hearing aids for dependent children under the age of 18 are covered in compliance with §10-16-104(19), C.R.S.

[25b] Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

[26] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[27] Grievances. Colorado law requires all plans to use consistent grievance procedures. Contact 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)

(Guidelines are for Basic and Standard, unless otherwise noted)

Breast Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Beginning at age 40, 1 clinical breast exam every 1 to 2 years (annually, if high risk).	As jointly determined by physician and patient
Mammogram	Beginning at age 40, 1 screening mammogram every 1 to 2 years (annually, if high risk).	At least every 2 years, particularly after 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)	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Adults ages 50-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. High risk patients may start at an earlier age.	Every 10 years, beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Beginning at age 19, not to exceed 1 per year	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal Pap smears and not high risk.

Prostate Cancer:

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient.
Serum prostatic specific antigen (PSA)	Basic: Not Covered Standard: As specified in State law	As jointly determined by physician and patient. Not recommended for those over 75.

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