KAISER PERMANENTE®

2012 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Plan 630 DHMO – CITY AND COUNTY OF DENVER, Group #00075 Revised
Denver/Boulder – Large Group

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 Year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	a) $500 per calendar year b) $1,500 per calendar year The Individual and Family Deductibles are separate Deductibles. For Families, individual family members are responsible for meeting the Family Deductible, only up to the Individual Deductible amount. If your group has a Pharmacy Deductible, please see Box 11 for information regarding the Pharmacy Deductible. (Note: The Pharmacy Deductible is separate from the medical Deductible (Deductible), noted above)
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,500 per calendar year b) $5,000 per calendar year c) No For Families, the individual family members are responsible for meeting the Family Out-of Pocket (OPM), only up to the Individual OPM amount.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	None
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers

2012 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
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**	*Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* a) $30 Copayment each primary care office visit b) $50 Copayment each specialist care office visit *Subject to the Deductible; applies to the OPM* No Charge (100% covered) for procedures received during an office visit after Deductible is met
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	*Not subject to the Deductible; does not apply to the OPM* a) No Charge (100% covered) b) No Charge (100% covered) The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance listed above.
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	a) Routine Prenatal Care - *Not subject to the Deductible; does not apply to the OPM* No Charge (100% covered) *Subject to the Deductible; applies to the OPM* 20% Coinsurance for procedures received during an office visit after Deductible is met. b) *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance - subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	*Not subject to the Deductible; does not apply to the OPM* $20 Generic/$40 Brand(preferred)/$60 non-preferred up to a 30-day supply, per prescription Mail-order drugs available for up to a 90-day supply for two Copayments For drugs on our approved list, please contact your Clinical Pharmacy Call Center at 303-338-4503 or toll-free at 1-866-244-4119 or TTY 1-800-521-4874.
12. INPATIENT HOSPITAL	*Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met 20% Coinsurance for inpatient professional visits after Deductible is met.
13. OUTPATIENT/AMBULATORY SURGERY	*Subject to the Deductible; applies to the OPM* 20% Coinsurance for outpatient surgery performed in any setting other than inpatient after Deductible is met.

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	a) Diagnostic Lab *Not subject to the Deductible; does not apply to the OPM* No Charge (100% covered) for laboratory services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility

	(excluding Plan Hospitals) *Subject to the Deductible; applies to the OPM* 20% Coinsurance for laboratory services in the outpatient department of a Plan Hospital after Deductible is met. Diagnostic X-ray, including Therapeutic – *Subject to the Deductible; applies to the OPM* 20% Coinsurance after Deductible is met. b) MRI/CT/PET – *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met
15. EMERGENCY CARE[7], [8]	*Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $200 Copayment at a Kaiser Permanente designated Plan or non-Plan emergency room 20% Coinsurance for Line 14b procedures (Special Procedures) performed while receiving Emergency Services after Deductible is met
16. AMBULANCE	*Not subject to the Deductible; does not apply to the OPM* 20% Coinsurance up to $500 per trip
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	a) Urgent care[7] *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $200 Copayment at a Kaiser Permanente designated Plan or non-Plan emergency room after Deductible is met 20% Coinsurance for Line 14b procedures (Special Procedures) performed while receiving Emergency Services after Deductible is met b) Non-routine care *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $30 Copayment at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area during office hours *Subject to the Deductible; applies to the OPM* 20% Coinsurance for procedures received during the visit after Deductible is met. c) After-hours care *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $75 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area 20% Coinsurance for procedures received during the visit after Deductible is met

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
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**	a) Inpatient *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met *Subject to the Deductible; applies to the OPM* 20% Coinsurance for inpatient professional visits after Deductible is met. b) Outpatient *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $30 Copayment Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar.
20. ALCOHOL & SUBSTANCE ABUSE	a) Inpatient Medical Detoxification *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance - subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* 20% Coinsurance after Deductible is met *Subject to the Deductible; applies to the OPM* 20% Coinsurance for inpatient professional visits after Deductible is met b) Outpatient Chemical Dependency *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance -- subject to the Deductible; applies to OPM* $30 Copayment Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar.

2012 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	For conditions subject to significant improvement within two (2) months Inpatient – *Subject to the Deductible; applies to the OPM* 20% Coinsurance after Deductible is met Outpatient *Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance - subject to the Deductible; applies to OPM* $30 Copayment each visit for up to 20 visits per year for each type of therapy (i.e. physical, occupational and speech therapy) Therapy for congenital defects and birth abnormalities are covered for children from age 3 to age 6 for both acute and chronic conditions. For children ages 0-3 services may be available as part of Early Intervention Services as defined by State law. Therapies for the treatment of autism spectrum disorders are not subject to any visit limits and include long term rehabilitation.
22. DURABLE MEDICAL EQUIPMENT	*Not subject to the Deductible; does not apply to the OPM* 20% Coinsurance within the Service Area - $2,000 annual benefit maximum per calendar year Prosthetic arms and legs covered at 20% Coinsurance with no annual maximum (the coinsurance must equal DME coinsurance or 20% whichever is lower). See policy for types and circumstances of coverage
23. OXYGEN	*Not subject to the Deductible; does not apply to the OPM* 20% Coinsurance
24. ORGAN TRANSPLANTS	a) Inpatient – see Box 12, Inpatient Hospital b) Outpatient – see applicable benefit in this Health Benefit Plan Description Form Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. *Subject to the Deductible; applies to the OPM* 20% Coinsurance for inpatient professional visits after Deductible is met.
25. HOME HEALTH CARE	*Subject to the Deductible; applies to the OPM* 20% Coinsurance for prescribed medically necessary part-time home health services after Deductible is met. Not covered outside the Service Area.
26. HOSPICE CARE	*Subject to the Deductible; applies to the OPM* 20% Coinsurance for hospice care after Deductible is met. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	*Subject to the Deductible; applies to the OPM* 20% Coinsurance for up to 100 days per calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities after Deductible is met. Not covered outside the Service Area.
28. DENTAL CARE	Not covered
29. VISION CARE	*Copayment --not subject to the Deductible; does not apply to the OPM* *Coinsurance --subject to the Deductible; applies to OPM* $30 Copayment per eye wellness and refraction exams performed by an Optometrist Hardware not covered.
30. CHIROPRACTIC CARE	*Not subject to the Deductible; does not apply to the OPM* $30 Copayment each visit for up to 20 visits per calendar year
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Pre-Hospice Special Services Hospice Program, Hearing aids for minors, Travel Clinic-pre-travel assessment/ prescription, Post-mastectomy breast reconstruction, Kaiser Permanente Cancer Screening Guidelines (attached)

2012 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado

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. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	Member Services can be reached at 303-338-3800 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874
40. Whom do I write/call if I have a complaint or want to file a grievance? [11]	Member Services 2500 South Havana Street Aurora, CO 80014-1622 303-338-3800 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms LG-DHMO-EOC-DENCOS(01-12) and GA-DENCOS(01-12) Large 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 Plan Benefit Description Form Addendum
Kaiser Permanente Cancer Screening Guidelines
(Charges may apply)

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Annually	As jointly determined by physician and patient
Mammogram	Available annually for all women beginning at age 40 or earlier based upon patient 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 (FIT)	Annually after age 50	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	On an individual basis	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Every 10 years, more frequently for high risk patients	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	Annually	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	Annually	As jointly determined by physician and patient
Serum prostatic specific antigen (PSA)	Annually	As jointly determined by physician and patient. Not recommended for those over 75.