



**2007 Colorado Health Plan Description Form
Kaiser Foundation Health Plan of Colorado**

\$2,000 Deductible Plan (70%) with Rx, \$2,000 Deductible Plan (70%), and \$5,000 Deductible Plan (70%)

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

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

	\$2,000 DEDUCTIBLE PLAN WITH Rx IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$2,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$5,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
4. ANNUAL DEDUCTIBLE² a) Individual b) Family	a) \$2,000 per calendar year b) \$6,000 per calendar year	a) \$2,000 per calendar year b) \$6,000 per calendar year	a) \$5,000 per calendar year b) \$15,000 per calendar year
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$5,000 per calendar year b) \$10,000 per calendar year c) No, the out-of-pocket maximum excludes deductible and copayments	a) \$5,000 per calendar year b) \$10,000 per calendar year c) No, the out-of-pocket maximum (OPM) excludes deductible and copayments	a) \$5,000 per calendar year b) \$10,000 per calendar year c) No, the out-of-pocket maximum excludes deductible and copayments
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum <u>Benefit Maximum(s)</u> Transplant Lifetime Maximum \$1,000,000 per Individual; \$25,000 Bone Marrow Donor Search per Individual The \$25,000 bone marrow donor search does not apply towards the Transplant Lifetime Maximum or the Lifetime Maximum.	No Lifetime Maximum <u>Benefit Maximum(s)</u> Transplant Lifetime Maximum \$1,000,000 per Individual; \$25,000 Bone Marrow Donor Search per Individual The \$25,000 bone marrow donor search does not apply towards the Transplant Lifetime Maximum or the Lifetime Maximum.	No Lifetime Maximum <u>Benefit Maximum(s)</u> Transplant Lifetime Maximum \$1,000,000 per Individual; \$25,000 Bone Marrow Donor Search per Individual The \$25,000 bone marrow donor search does not apply towards the Transplant Lifetime Maximum or the Lifetime Maximum.

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PART B: SUMMARY OF BENEFITS CONTINUED

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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. ROUTINE MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	a) \$30 copay per primary care office visit, not subject to deductible b) \$50 copay per specialist care office visit, not subject to deductible 30% coinsurance for procedures received during an office visit, after deductible is met	a) \$30 copay per primary care office visit, not subject to deductible b) \$50 copay per specialist care office visit, not subject to deductible 30% coinsurance for procedures received during an office visit, after deductible is met	a) \$30 copay per primary care office visit, not subject to deductible b) \$50 copay per specialist care office visit, not subject to deductible 30% coinsurance for procedures received during an office visit, after deductible is met
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) No charge (100% covered), not subject to deductible b) No charge (100% covered), not subject to deductible	a) No charge (100% covered), not subject to deductible b) No charge (100% covered), not subject to deductible	a) No charge (100% covered), not subject to deductible b) No charge (100% covered), not subject to deductible
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	Not Covered	Not Covered	Not Covered

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11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions	\$200 pharmacy deductible per person, does not apply to annual deductible \$15 generic/\$30 brand-name/50% non-preferred (does not apply to OPM) per prescription up to a 30-day supply, after pharmacy deductible is met Mail-order drugs available for up to a 90-day supply for two copays For drugs on our approved list, please contact your Clinical Pharmacy Call Center at 303-388-4503	Not Covered	Not Covered
12. INPATIENT HOSPITAL	30% coinsurance after deductible is met. 30% coinsurance for inpatient professional visits, after deductible is met.	30% coinsurance after deductible is met. 30% coinsurance for inpatient professional visits, after deductible is met.	30% coinsurance after deductible is met. 30% coinsurance for inpatient professional visits, after deductible is met.
13. OUTPATIENT/ AMBULATORY SURGERY	30% coinsurance for outpatient surgery performed in any setting other than inpatient, after deductible is met	30% coinsurance for outpatient surgery performed in any setting other than inpatient, after deductible is met	30% coinsurance for outpatient surgery performed in any setting other than inpatient, after deductible is met
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	a) Diagnostic Lab - No charge (100% covered), not subject to deductible X-ray, including Therapeutic - 30% coinsurance after deductible is met b) MRI/CT/PET - 30% coinsurance after deductible is met	a) Diagnostic Lab - No charge (100% covered), not subject to deductible X-ray, including Therapeutic - 30% coinsurance after deductible is met b) MRI/CT/PET - 30% coinsurance after deductible is met	a) Diagnostic Lab - No charge (100% covered), not subject to deductible X-ray, including Therapeutic - 30% coinsurance after deductible is met b) MRI/CT/PET - 30% coinsurance after deductible is met
15. EMERGENCY CARE^{7,8}	30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met	30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met	30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met
16. AMBULANCE	30% coinsurance up to \$500 per trip, not subject to deductible	30% coinsurance up to \$500 per trip, not subject to deductible	30% coinsurance up to \$500 per trip, not subject to deductible

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17. URGENT, NON-ROUTINE, AFTER-HOURS CARE a) Urgent care⁸ b) Non-routine care c) After-hours care	a) 30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met b) \$30 copay per visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan emergency room outside the Service Area, during office hours, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met c) \$75 copay per after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met	a) 30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met b) \$30 copay per visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan emergency room outside the Service Area, during office hours, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met c) \$75 copay per after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met	a) 30% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met b) \$30 copay per visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan emergency room outside the Service Area, during office hours, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met c) \$75 copay per after-hours visit at Kaiser Permanente designated after-hours Plan Facility inside the Service Area, not subject to deductible; 30% coinsurance for procedures received during the visit, after deductible is met
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	See line 19, Other Mental Health Care		
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) <u>Inpatient</u> - Not Covered b) <u>Outpatient</u> - one consultation per calendar year is provided at a 50% coinsurance, not subject to deductible	a) <u>Inpatient</u> - Not Covered b) <u>Outpatient</u> - one consultation per calendar year is provided at a 50% coinsurance, not subject to deductible	a) <u>Inpatient</u> - Not Covered b) <u>Outpatient</u> - one consultation per calendar year is provided at a 50% coinsurance, not subject to deductible

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PART B: SUMMARY OF BENEFITS CONTINUED

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20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient b) Outpatient	<p>a) <u>Inpatient Medical Detoxification</u> - 30% coinsurance per admission after deductible is met. Detoxification is limited to removing toxic substance from the body.</p> <p><u>Inpatient Residential Rehabilitation</u> - Not Covered</p> <p>b) <u>Outpatient Chemical Dependency</u> - one consultation per calendar year is provided at 50% coinsurance, not subject to deductible</p>	<p>a) <u>Inpatient Medical Detoxification</u> - 30% coinsurance per admission after deductible is met. Detoxification is limited to removing toxic substance from the body.</p> <p><u>Inpatient Residential Rehabilitation</u> - Not Covered</p> <p>b) <u>Outpatient Chemical Dependency</u> - one consultation per calendar year is provided at 50% coinsurance, not subject to deductible</p>	<p>a) <u>Inpatient Medical Detoxification</u> - 30% coinsurance per admission after deductible is met. Detoxification is limited to removing toxic substance from the body.</p> <p><u>Inpatient Residential Rehabilitation</u> - Not Covered</p> <p>b) <u>Outpatient Chemical Dependency</u> - one consultation per calendar year is provided at 50% coinsurance, not subject to deductible</p>
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	<p>For conditions subject to significant improvement within two months</p> <p>*<u>Inpatient</u> - 30% coinsurance per admission for physical therapy only. (Occupational and speech therapy are not covered)</p> <p>*<u>Outpatient</u> - \$30 copay per visit for up to 20 visits or up to two months per condition, not subject to deductible</p> <p>*Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions</p>	<p>For conditions subject to significant improvement within two months</p> <p>*<u>Inpatient</u> - 30% coinsurance per admission for physical therapy only. (Occupational and speech therapy are not covered)</p> <p>*<u>Outpatient</u> - \$30 copay per visit for up to 20 visits or up to two months per condition, not subject to deductible</p> <p>*Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions</p>	<p>For conditions subject to significant improvement within two months</p> <p>*<u>Inpatient</u> - 30% coinsurance per admission for physical therapy only. (Occupational and speech therapy are not covered)</p> <p>*<u>Outpatient</u> - \$30 copay per visit for up to 20 visits or up to two months per condition, not subject to deductible</p> <p>*Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions</p>
22. DURABLE MEDICAL EQUIPMENT	<p>No supplemental benefit</p> <p>Prosthetic arms and legs covered at 20% coinsurance with no annual maximum benefit, not subject to deductible</p>	<p>No supplemental benefit</p> <p>Prosthetic arms and legs covered at 20% coinsurance with no annual maximum benefit, not subject to deductible</p>	<p>No supplemental benefit</p> <p>Prosthetic arms and legs covered at 20% coinsurance with no annual maximum benefit, not subject to deductible</p>
23. OXYGEN	Not Covered	Not Covered	Not Covered

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24. ORGAN TRANSPLANTS	30% coinsurance after deductible is met - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 30% coinsurance for inpatient professional visits, after deductible is met	30% coinsurance after deductible is met - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 30% coinsurance for inpatient professional visits, after deductible is met	30% coinsurance after deductible is met - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 30% coinsurance for inpatient professional visits, after deductible is met
25. HOME HEALTH CARE	30% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area.	30% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area.	30% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area.
26. HOSPICE CARE	30% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area.	30% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area.	30% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	30% coinsurance for up to 100 days each calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities, after deductible is met. Not covered outside the Service Area.	30% coinsurance for up to 100 days each calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities, after deductible is met. Not covered outside the Service Area.	30% coinsurance for up to 100 days each 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	Not Covered	Not Covered
29. VISION CARE	Not Covered	Not Covered	Not Covered
30. CHIROPRACTIC CARE	Not Covered	Not Covered	Not Covered

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PART C: LIMITATIONS AND EXCLUSIONS

	\$2,000 DEDUCTIBLE PLAN WITH Rx IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$2,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$5,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Health education classes including Smoking Cessation, Stress Management, Women’s Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; Limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area		
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED¹⁰	Not applicable. Plan does not impose limitation periods for pre-existing conditions.		
33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No		
34. HOW DOES THE POLICY DEFINE A “PRE-EXISTING CONDITION”?	Not applicable. Plan does not exclude coverage for pre-existing conditions.		
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g. employer). Review them to see if a service of treatment you may need is excluded from the policy.		

PART D: USING THE PLAN

	\$2,000 DEDUCTIBLE PLAN WITH Rx IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$2,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$5,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No		

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PART D: USING THE PLAN CONTINUED

	\$2,000 DEDUCTIBLE PLAN WITH Rx IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$2,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	\$5,000 DEDUCTIBLE PLAN IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
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 303-338-3820 (TTY)		
40. Whom do I write/call if I have a complaint or want to file a grievance?¹¹	Member Services 2500 South Havana Street Aurora, CO 80014 303-338-3800 or 303-338-3820		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy form KPIF2000Rx-DEN(01-07) Individual	Policy form KPIF2000-DEN(01-07) Individual	Policy form KPIF5000-DEN(01-07) Individual
43. Does the plan have a binding arbitration clause?	Yes		

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Endnotes

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

² “Deductible” 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) 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 may be noted in boxes 8 through 31.

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 may be noted in boxes 8 through 31.

⁴ “Routine 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 services delivered by 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 Description Form Addendum
Kaiser Permanente Cancer Screening Guidelines
(Charges may apply)**

Breast Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Not limited	As jointly determined by physician and patient
Mammogram	Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider for those women who meet the following criteria: Patients with a 10% or greater risk of inherited gene defect	

Colon and Rectal Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Fecal occult blood test (FOBT)	Not limited	Annually beginning at age 50 through age 75
Flexible sigmoidoscopy	Not limited	Every 5 – 10 years beginning at age 50 through age 75
Barium enema	Not limited	Every 5 years beginning at age 50 through age 75
Colonoscopy	Every 10 years, more frequently for high risk patients — as determined by a Kaiser Permanente physician	Every 10 years, more frequently for high risk patients — as determined by a Kaiser Permanente physician

Cervical Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Not limited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.

Prostate Cancer:

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