



2009 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
MultiChoice POS 750B
Denver Boulder - Small Group

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of Service (i.e., an HMO plan with some out-of-network benefits)
2. OUT-OF-NETWORK CARE COVERED?¹	Yes, but patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: Denver and Boulder Counties and portions of Adams, Arapahoe, Broomfield, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties as determined by zip code

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
4. Deductible Type²	Calendar Year	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a} a) Individual^{2b} b) Family^{2c}	a) \$750 / Individual per calendar year b) \$2,250 / Family per calendar year	a) \$750 / Individual per calendar year b) \$2,250 / Family per calendar year	a) \$1,500 / Individual per calendar year b) \$4,500 / Family 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. Note: The Pharmacy Deductible is separate from the medical Deductible ("Deductible"), noted above. Please see Box 11 for information regarding the Pharmacy Deductible, if applicable.		
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$2,000 / Individual per calendar year b) \$4,000 / Family per calendar year c) No	a) \$2,000 / Individual per calendar year b) \$4,000 / Family per calendar year c) No	a) \$6,000 / Individual per calendar year b) \$12,000 / Family per calendar year c) No
	For Families, the individual family members are responsible for meeting the Family OPM, only up to the Individual OPM amount.		

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	<p><u>Lifetime Maximum</u> No Lifetime Maximum</p> <p>The Lifetime Maximum represents the combined benefit maximum for all covered services.</p> <p><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 toward the Transplant Lifetime Maximum or the Lifetime Maximum.</p>	\$2,000,000 Combined Maximum Benefit while insured	
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers at www.kp.org	Private Healthcare Systems, Inc. (PHCS). See online Provider Directory for complete list at www.kp.org	All providers licensed or certified to provide covered benefits
7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?	Yes	Yes	Not Applicable
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	<p>Not subject to Deductible; does not apply toward OPM</p> <p>a) \$20 Copayment each primary care office visit</p> <p>b) \$30 Copayment each specialist care office visit</p> <p>10% Coinsurance for procedures received during an office visit (including Office Administered Drugs), after Deductible is met (Note: procedures received during an office visit are subject to Deductible; apply toward OPM)</p>	<p>Not subject to Deductible; does not apply toward OPM</p> <p>a) \$20 Copayment per primary care office visit</p> <p>b) \$30 Copayment each specialist care office visit</p> <p>Only Diagnostic Lab and X-ray performed in a physician's office are included in the office visit Copayment. 10% Coinsurance applies after Deductible is met for all other services</p>	<p>Subject to Deductible; applies toward OPM</p> <p>a) 40% Coinsurance after Deductible is met.</p> <p>b) 40% Coinsurance after Deductible is met.</p>
	Routine Lab & Diagnostic X-ray orders may be brought to Kaiser Permanente facilities and completed at the IN-NETWORK benefit level		

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
<p>9. PREVENTIVE CARE a) Children's services b) Adults' services</p>	<p>Not subject to Deductible; does not apply toward OPM a) No Charge (100% covered) b) No Charge (100% covered)</p>	<p>Not subject to Deductible; does not apply toward OPM a) No Charge (100% covered) b) No Charge (100% covered) Limited adult services available</p>	<p>Not subject to Deductible; does not apply toward OPM a) 40% Coinsurance b) 40% Coinsurance Limited adult services available</p>
<p>10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵</p>	<p>a) Not subject to Deductible; does not apply toward OPM No Charge (100% covered) 20% Coinsurance for procedures received during an office visit (Note: procedures received during an office visit are subject to Deductible; applies toward OPM) b) Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met</p>	<p>a) Not subject to Deductible; does not apply toward OPM No Charge (100% covered) 20% Coinsurance for procedures received during an office visit (Note: procedures received during an office visit are subject to Deductible; applies toward OPM) b) Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met</p>	<p>a) Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met b) Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met</p>
<p>11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions.</p>	<p>Not subject to Deductible; does not apply toward OPM \$20 Copayment for Generic/\$30 Copayment for Brand name/\$45 Copayment for Non-preferred/20% Coinsurance for Specialty Drugs up to a maximum of \$250 per drug dispensed/ up to a 30-day supply Mail-order drugs available for up to a 90 day supply for two Copayments. Certain drugs are limited to a 30-day supply For drugs on our approved list, please contact your Clinical Pharmacy Call Center at 303-338-4503 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874.</p>	<p>Not subject to Deductible; does not apply toward OPM \$25 Copayment for Preferred Generic/\$40 Copayment for Preferred Brand name/\$55 Copayment for Non-preferred /20% Coinsurance for Specialty Drugs (including certain self-administered injectables) up to a maximum of \$250 per drug dispensed Limited to a 30-day supply through MedImpact pharmacies Mail-order drugs available for up to a 90-day supply for two Copayments No coverage at Out-of-Network pharmacies For drugs on the MedImpact Preferred Drug List, or to locate Network pharmacies, please contact MedImpact toll-free at 800-788-2949. or visit www.kp.org Prescriptions for medications on the Kaiser Permanente formulary may also be filled at Kaiser Permanente pharmacies for the applicable IN-NETWORK benefit</p>	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met 10% Coinsurance for inpatient professional visits, after Deductible is met	Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met – Precertification required	Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met – Precertification required
13. OUTPATIENT/ AMBULATORY SURGERY	Subject to Deductible; applies toward OPM 10% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met	Subject to Deductible; applies toward OPM 10% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met – Precertification required	Subject to Deductible; applies toward OPM 40% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met – Precertification required
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	a) <u>Diagnostic Lab</u> - Not subject to Deductible; does not apply toward OPM No Charge (100% covered) <u>X-ray, including Therapeutic</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met b) <u>MRI/CT/PET</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met	a) <u>Diagnostic Lab</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met <u>X-ray, including Therapeutic</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met b) <u>MRI/CT/PET</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met. Precertification required for MRI/CT/PET.	a) <u>Diagnostic Lab</u> - Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met <u>X-ray, including Therapeutic</u> - Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met b) <u>MRI/CT/PET</u> - Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met. Precertification required for MRI/CT/PET.
	Routine Lab and Diagnostic X-ray orders may be brought to Kaiser Permanente facilities and completed at the IN-NETWORK benefit level		
15. EMERGENCY CARE^{7,8}	Subject to Deductible; applies toward OPM 10% Coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after Deductible is met	Covered as IN-NETWORK benefit, regardless of location	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
16. AMBULANCE	<p>Not subject to Deductible; does not apply toward OPM</p> <p>10% Coinsurance up to \$500 per trip</p>	<p>Covered as IN-NETWORK benefit, regardless of location</p>	
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	<p>a) <u>Urgent care</u>⁷ - Subject to Deductible; applies toward OPM 10% Coinsurance at a Kaiser Permanente designated Plan emergency room inside the Service Area or a non-Plan emergency room outside the Service Area, after Deductible is met</p> <p>b) <u>Non-routine care</u> - Not subject to Deductible; does not apply toward OPM \$20 Copayment at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area during office hours 10% Coinsurance for procedures received during the visit, after Deductible is met (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p> <p>c) <u>After-hours care</u> - Not subject to Deductible; does not apply toward OPM \$30 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility, inside the Service Area; 10% Coinsurance for procedures received during the visit, after Deductible is met. (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p>	<p>a) <u>Urgent care</u>⁷ - Subject to Deductible; applies toward OPM 10% Coinsurance at a participating provider Urgent Care facility, after Deductible is met Emergency Room Care covered as IN-NETWORK benefit</p> <p>b) <u>Non-routine care</u> - Not subject to Deductible; does not apply toward OPM \$20 Copayment during normal office hours at a PREFERRED PROVIDER medical office 10% Coinsurance for procedures received during the visit, after Deductible is met (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p> <p>c) <u>After-hours care</u> - Not subject to the Deductible; does not apply toward OPM \$30 Copayment each after-hours visit, at PREFERRED PROVIDER NETWORK medical office. 10% Coinsurance for procedures received during the visit, after Deductible is met. (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p>	<p>a) <u>Urgent care</u>⁷ - Subject to Deductible; applies toward OPM 40% Coinsurance at a OUT-OF-NETWORK Urgent Care facility, after Deductible is met Emergency Room Care covered as IN-NETWORK benefit</p> <p>b) <u>Non-routine care</u> - Subject to the Deductible; applies toward OPM 40% Coinsurance after Deductible is met, at an OUT-OF-NETWORK medical office 40% Coinsurance for procedures received during the visit, after Deductible is met (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p> <p>c) <u>After-hours care</u> - Subject to the Deductible; applies toward OPM 40% Coinsurance after Deductible is met, each after-hours visit at an OUT-OF-NETWORK medical office. 40% Coinsurance for procedures received during the visit, after Deductible is met. (Note: procedures received during the visit are subject to Deductible; apply toward OPM)</p>

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	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) <u>Inpatient</u> - Subject to Deductible; applies toward OPM 10% Coinsurance up to 45 days per calendar year, after Deductible is met b) <u>Outpatient</u> - Not subject to Deductible; does not apply toward OPM 50% Coinsurance up to 20 visits per calendar year 50% Coinsurance after Deductible is met for inpatient professional visits. (Note: inpatient professional visits subject to Deductible; apply toward OPM)	a) <u>Inpatient</u> - Benefits covered IN-NETWORK only b) <u>Outpatient</u> - Not subject to Deductible; does not apply toward OPM 50% Coinsurance	a) <u>Inpatient</u> - Benefits covered IN-NETWORK only b) <u>Outpatient</u> - Subject to Deductible; applies toward OPM 50% Coinsurance, after Deductible is met
		Combined (PREFERRED PROVIDER and OUT-OF-NETWORK) maximum of 20 visits per calendar year for outpatient visits	
20. ALCOHOL & SUBSTANCE ABUSE	a) <u>Inpatient Medical Detoxification</u> - Subject to Deductible; applies toward OPM 10% Coinsurance, after Deductible is met. Detoxification is limited to removing toxic substance from the body <u>Inpatient Residential Rehabilitation</u> – Not covered b) <u>Outpatient Chemical Dependency</u> - Not subject to Deductible; does not apply toward OPM 50% Coinsurance up to 20 visits per calendar year 50% Coinsurance for inpatient professional visits, after deductible is met. (Note: inpatient professional visits subject to Deductible; apply toward OPM)	a) <u>Inpatient Medical Detoxification</u> - Benefits covered IN-NETWORK only <u>Inpatient Residential Rehabilitation</u> - Benefits covered IN-NETWORK only b) <u>Outpatient Chemical Dependency</u> – Benefits covered IN-NETWORK only	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	For conditions subject to significant improvement within two months		
	<p>*<u>Inpatient</u> - Subject to Deductible; applies toward OPM 10% Coinsurance after Deductible is met, up to 60 days per calendar year</p> <p>*<u>Outpatient</u> - Not subject to Deductible; does not apply toward OPM \$20 Copayment each visit for up to 20 visits per year for each type of therapy (i.e. physical, occupational and speech therapy)</p> <p>*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</p>	<p>*<u>Inpatient</u> – Benefits covered IN-NETWORK only</p> <p>*<u>Outpatient</u> – Not subject to Deductible; does not apply toward OPM \$20 Copayment each visit</p>	<p>*<u>Inpatient</u> – Benefits covered IN-NETWORK only</p> <p>*<u>Outpatient</u> – Subject to Deductible; applies toward OPM 40% Coinsurance after Deductible is met</p>
22. DURABLE MEDICAL EQUIPMENT	<p>Not subject to Deductible; does not apply toward OPM</p> <p>10% Coinsurance within the Service Area, \$2,000 annual maximum benefit per year.</p> <p>Prosthetic arms and legs covered at 10% Coinsurance with no annual maximum. See policy for types and circumstances of coverage.</p>	<p>Not subject to Deductible; does not apply toward OPM</p> <p>Prosthetic replacement of arms or legs covered at 20% Coinsurance after Deductible is met with no annual maximum.</p>	<p>Not subject to Deductible; does not apply toward OPM</p> <p>Prosthetic replacement of arms or legs covered at 20% Coinsurance after Deductible is met with no annual maximum.</p>
		<p>All other DME must be ordered through IN-NETWORK vendors. See IN-NETWORK policy for types and circumstances of coverage.</p>	
23. OXYGEN	<p>Not subject to Deductible; does not apply toward OPM</p> <p>10% Coinsurance</p>	Benefits covered IN-NETWORK only	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS	<p>Subject to Deductible; applies toward OPM</p> <p>10% 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</p> <p>10% Coinsurance for inpatient professional visits, after Deductible is met (Note: inpatient professional visits subject to Deductible; apply toward OPM)</p>	Benefits covered IN-NETWORK only	
25. HOME HEALTH CARE	<p>Subject to Deductible; applies toward OPM</p> <p>10% Coinsurance for prescribed medically necessary part-time home health services, after Deductible is met. Not covered outside the Service Area.</p>	Subject to Deductible; applies toward OPM	
		Combined maximum of 60 home health visits per calendar year	
26. HOSPICE CARE	<p>Subject to Deductible; applies toward OPM</p> <p>10% Coinsurance for hospice care, after Deductible is met. Not covered outside the Service Area.</p>	Subject to Deductible; applies toward OPM	
		Limited to \$100 per day per benefit period (3 months) to a combined maximum while insured of 3 benefit periods for hospice care program; precertification required	
		10% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
27. SKILLED NURSING FACILITY CARE	<p>Subject to Deductible; applies toward OPM</p> <p>10% 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.</p>	Subject to Deductible; applies toward OPM	
		Limited to \$100 per day per benefit period (3 months) to a combined maximum while insured of 3 benefit periods for hospice care program; precertification required	
		10% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met
28. DENTAL CARE	Dental benefits are available through a partnership with Delta Dental.		

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
29. VISION CARE	Not subject to Deductible; does not apply toward OPM \$20 Copayment per eye wellness and refraction exams performed by an Optometrist. Hardware not covered	Not Covered	
30. CHIROPRACTIC CARE	Not Covered	Not subject to Deductible; does not apply toward OPM \$30 Copayment per visit, limited to 20 visits per calendar year.	Not Covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Travel Clinic for pre-travel health risk assessments, immunizations (except for immunizations exclusively used for travel) and prescriptions; Mail-order Pharmacy; post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses and services due to complications; 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	See attached addendum for significant cancer screening services	

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
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	Not Applicable	

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PART C: LIMITATIONS AND EXCLUSIONS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
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	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
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	No	Yes
39. What is the main customer service number?	Member Services can be reached at 303-338-3800 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874		
40. Whom do I write/call if I have a complaint or want to file a grievance?¹¹	Member Services 2500 South Havana Street Aurora, CO 80014 303-338-3800 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202		

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PART D: USING THE PLAN CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
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 SG -POS-DHMO-EOC -DENCOS(01-09) and GA-Small DENCOS(01-09) Small Group		Policy forms #GC-POS-2004CO et seq. Small Group
43. Does the plan have a binding arbitration clause?	Yes		No

Endnotes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Breast Cancer:			
Screening	IN-NETWORK (Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation	PREFERRED PROVIDER and OUT-OF-NETWORK (Frequency subject to Physician recommendation)
Clinical breast exam	Unlimited	As jointly determined by physician and patient	Unlimited
Mammogram	Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50	For women age thirty-five (35) through age thirty-nine (39), one baseline mammogram; For women age forty (40) through age forty-nine (49), one mammogram every two years, or more frequently upon recommendation of a Physician; and For women age fifty (50) and older, 1 mammogram every twelve (12) months. Benefits are exempt from any Deductibles
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		Covered IN-NETWORK only
Colon and Rectal Cancer:			
Screening	IN-NETWORK (Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation	PREFERRED PROVIDER and OUT-OF-NETWORK (Frequency subject to Physician recommendation)
Fecal occult blood test (FOBT)	Unlimited	Annually beginning at age 50 through age 75	Between ages 40 – 64, either annual hemocults between ages 40 - 64 or between ages 50 – 70, two colorectal visualizations
Flexible sigmoidoscopy	Unlimited	Every 5 – 10 years beginning at age 50 through age 75	(See above)
Barium enema	Unlimited	Every 5 years beginning at age 50 through age 75	(See above)
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	Every 10 years, more frequently for high risk patients – as determined by your physician

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

Cervical Cancer:

Screening	IN-NETWORK (Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation	PREFERRED PROVIDER and OUT-OF-NETWORK (Frequency subject to Physician recommendation)
Pap test	Unlimited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.	One office visit per calendar year for a pelvic examination and pap smear testing

Prostate Cancer:

Screening	IN-NETWORK (Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation	PREFERRED PROVIDER and OUT-OF-NETWORK (Frequency subject to Physician recommendation)
Digital rectal exam	Unlimited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician	For men age fifty (50) and older, one screening per calendar year For men age forty (40) through age forty-nine (49), one screening per calendar year if the Covered Person's Physician determines he is at high risk of developing prostate cancer Benefits are limited to a maximum payment of the lesser of the actual charge or \$65 per screening Benefits are exempt from any Deductibles
Serum prostatic specific antigen (PSA)	Unlimited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician. Not recommended for those over 70.	For men age fifty (50) and older, one screening per calendar year For men age forty (40) through age forty-nine (49), one screening per calendar year if the Covered Person's Physician determines he is at high risk of developing prostate cancer Benefits are limited to a maximum payment of the lesser of the actual charge or \$65 per screening Benefits are exempt from any Deductibles