



**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**

<b>1. TYPE OF PLAN</b>	Health Maintenance Organization (HMO)
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Only for Emergency Care
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available <b>only</b> 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.

	<b>IN-NETWORK ONLY</b> (Out-of-Network care is not covered except as noted)
<b>4. Deductible Type<sup>2</sup></b>	Not Applicable
<b>4a. ANNUAL DEDUCTIBLE<sup>2a</sup></b> a) Individual <sup>2b</sup> b) Family <sup>2c</sup>	a) No Deductibles b) No Deductibles
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$3,000/Individual b) \$6,000/Family c) Not Applicable
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	No Lifetime Maximum
<b>7A. COVERED PROVIDERS</b>	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers.
<b>7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?</b>	Yes
<b>8. MEDICAL OFFICE VISITS<sup>4</sup></b> a) Primary Care Providers b) Specialists	Applies toward Out-of-Pocket Maximum (OPM)  a) \$25 Copayment each primary care office visit b) \$40 Copayment each specialist office visit  Line 13 may apply for procedures performed during an office visit
<b>9. PREVENTIVE CARE</b> a) Children's services b) Adults' services	Applies toward OPM  a) \$25 Copayment each visit b) \$25 Copayment each visit

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**PART B: SUMMARY OF BENEFITS CONTINUED**

	<b>IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)</b>
<b>10. MATERNITY</b> a) Prenatal care b) Delivery & inpatient well baby care <sup>5</sup>	Applies toward OPM  a) One-time \$25 Copayment for all routine prenatal visits combined b) \$250 Copayment per day up to \$1,000 per admission
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b> Level of coverage and restrictions on prescriptions.	Does not apply toward OPM  \$10 Copayment – preferred generic, \$40 Copayment – preferred brand-name, or \$60 Copayment – non-preferred up to a 30-day supply. Mail order drugs filled for a 90-day supply at two Copayments.  For drugs on our approved list, please contact your Clinical Pharmacy Call Center at <b>303-338-4503</b> or toll-free at <b>1-800-632-9700</b> or TTY <b>1-800-521-4874</b> .
<b>12. INPATIENT HOSPITAL</b>	Applies toward OPM  \$250 Copayment per day up to \$1,000 per admission
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	Applies toward OPM  \$150 Copayment each visit for outpatient surgery performed in any setting other than inpatient
<b>14. DIAGNOSTICS</b> a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	Applies toward OPM  a) <u>Diagnostic Lab and X-ray, including Therapeutic</u> – No Charge (100% covered) for physician ordered services b) <u>MRI/CT/PET</u> - \$150 Copayment per procedure
<b>15. EMERGENCY CARE<sup>7, 8</sup></b>	Applies toward OPM  \$150 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room
<b>16. AMBULANCE</b>	Applies toward OPM  \$100 Copayment per incident
<b>17. URGENT, NON-ROUTINE, AFTER-HOURS CARE</b>	Applies toward OPM  \$75 Copayment each visit at a Kaiser Permanente designated Plan medical office, or when temporarily traveling outside the Service Area.
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness
<b>19. OTHER MENTAL HEALTH CARE</b> a) Inpatient care b) Outpatient care	Applies toward OPM  a) <u>Inpatient</u> - 50% Coinsurance of non-member rates. Limited to 45 inpatient or 90 partial days per year b) <u>Outpatient</u> - 50% Coinsurance of non-member rates for the greater of 20 visits or \$1,500 maximum per year

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**PART B: SUMMARY OF BENEFITS CONTINUED**

	<b>IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)</b>
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b>	Applies toward OPM  50% Coinsurance for diagnosis, medical treatment and referral services only
<b>21. PHYSICAL, OCCUPATIONAL, &amp; SPEECH THERAPY</b>	Applies toward OPM  Limited to medically necessary therapeutic treatment <u>Inpatient</u> * – Hospital Copayment applies <u>Outpatient</u> * - \$25 Copayment each visit up to 25 visits per therapy (physical, speech and occupational therapy ) per year  *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.
<b>22. DURABLE MEDICAL EQUIPMENT</b>	Applies toward OPM  20% Coinsurance, up to a maximum of \$2,000 paid by Plan per year, within the Service Area. Prosthetic arms and legs covered at 20% Coinsurance which, applies toward the maximum, but is not limited to the maximum. (Includes oxygen). See policy for types and circumstances of coverage.
<b>23. OXYGEN</b>	Included in DME benefit
<b>24. ORGAN TRANSPLANTS</b>	Applies toward OPM  Applicable inpatient and outpatient charges apply - no waiting period. 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.
<b>25. HOME HEALTH CARE</b>	No Charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area.
<b>26. HOSPICE CARE</b>	No Charge (100% covered)
<b>27. SKILLED NURSING FACILITY CARE</b>	Applies toward OPM  \$50 Copayment per day up to 100 days per year for prescribed skilled nursing services at skilled nursing facilities approved by Kaiser Permanente
<b>28. DENTAL CARE</b>	Not covered except for accidental injuries and hospitalization and anesthesia for dependent children as required by law. Additional coverage available as a separate dental care plan or as an optional benefit
<b>29. VISION CARE</b>	Excluded
<b>30. CHIROPRACTIC CARE</b>	Not Covered [See line 31]
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) (1) Spinal manipulation</b>	Applies toward OPM  \$25 Copayment each visit

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**PART C: LIMITATIONS AND EXCLUSIONS**

	<b>IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)</b>
<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED<sup>10</sup></b>	Not Applicable. Plan does not impose limitation periods for pre-existing conditions.
<b>33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	Not Applicable. Plan does not exclude coverage for pre-existing conditions.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier

**PART D: USING THE PLAN**

	<b>IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No
<b>39. What is the main customer service number?</b>	Member Services can be reached toll-free at <b>303-338-3800</b> or toll-free at <b>1-800-632-9700</b> or TTY <b>1-800-521-4874</b>
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	Member Services 2500 South Havana Street Aurora, CO 80014 <b>303-338-3800</b> or toll-free <b>1-800-632-9700</b> or TTY <b>1-800-521-4874</b>
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
<b>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.</b>	Policy form SG-STEOC-DENCOS(01-09) and GA-Small-DENCOS(01-09) Small Group
<b>43. Does the plan have a binding arbitration clause?</b>	Yes

**Endnotes**

<sup>1</sup> "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).

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<sup>2</sup> “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.”

<sup>2a</sup> “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.

<sup>2b</sup> “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.

<sup>2c</sup> “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.

<sup>3</sup> “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.

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

<sup>5</sup> 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.

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

<sup>7</sup> “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.

<sup>8</sup> 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.

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

<sup>10</sup> 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.

<sup>11</sup> 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	Unlimited	As jointly determined by physician and patient
Mammogram	Basic: Not Covered Standard: Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider for those women who meet the following criteria: Patients with a 10% or greater risk of inherited gene defect	

**Colon and Rectal Cancer:**

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Fecal occult blood test (FOBT)	Unlimited	Annually beginning at age 50 through age 75
Flexible sigmoidoscopy	Unlimited	Every 5 – 10 years beginning at age 50 through age 75
Barium enema	Unlimited	Every 5 years beginning at age 50 through age 75
Colonoscopy	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician

**Cervical Cancer:**

Screening	(frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Unlimited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.

**Prostate Cancer:**

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