KAISER PERMANENTE®

STATE OF COLORADO FY12

Benefit	CURRENT HMO	High Deductible Plan with HSA Option
Annual Deductible		
Individual	No deductible	$1,200
Family	No deductible	$2,400
Out-of-Pocket Max		
Individual	$1,000	$2,500
Family	$3,000	$5,000
Lifetime Max	Unlimited	Unlimited
Office Visit Copayment		**All benefits subject to deductible & all coinsurance applies to OPM**
Primary Care	$30 copayment	10% coinsurance
Specialty Care	$50 copayment	10% coinsurance
Preventive Care	No charge (100% covered)	No charge (100% covered)
Maternity		
Prenatal Care	No charge (100% covered)	No charge (100% covered)
Inpatient/Delivery	$750 copayment	10% coinsurance
Prescription Drugs		
Generic	$10 copayment	$10 copayment. (after deductible, applies to OPM)
Brand	$30 copayment	$40 copayment. (after deductible, applies to OPM)
	up to a 30-day supply	up to a 30-day supply
Self-Injectibles	20% coinsurance up to a $75 max per script	20% coinsurance up to a $100 max per script
Mail order	Up to a 90 day supply available for two copayments	Up to a 90 day supply available for two copayments
Inpatient Hospital	$750 copayment	10% coinsurance
Outpatient / Ambulatory Care	$150 copayment	10% coinsurance
Diagnostics		
Diagnostic Lab and X ray	100% covered	10% coinsurance
Therapeutic X-Ray	$50 copayment per visit	10% coinsurance
MRI / CAT / PET	$100 copayment per procedure	10% coinsurance
Emergency Care	$100 copayment	10% coinsurance
Ambulance	20% coinsurance to max of $500 / trip	10% coinsurance
After-Hours Care	$50 copayment	10% coinsurance
Mental Health		
Inpatient Hospital	$750 copayment	10% coinsurance
Outpatient Care	$30 copayment	10% coinsurance
Chemical Dependency		
Inpatient	$750 copayment	10% coinsurance
Outpatient Care	$30 copayment	10% coinsurance
Physical, Occupational & Speech Therapy		
Inpatient Hospital	$750 copayment per admit	10% coinsurance
Outpatient Care	$30 copayment up to 20 visits per condition	10% coinsurance up to 20 visits per treatment per year
DME	Kaiser Permanente pays 100% up to $5,000	10% coinsurance up to $5000 per year
Oxygen	20% coinsurance	10% coinsurance
Organ Transplant	$750 copayment per admit	10% coinsurance
Home Health Care	100% covered	10% coinsurance
Hospice Care	100% covered	10% coinsurance
Skilled Nursing Facility	100% covered up to 100 days	10% coinsurance up to 100 days per year
Vision Care	$30 copayment / exam only	10% coinsurance / exam only
Chiropractic Care	$30 copayment / 20 visits per year	N/A

Traditional HMO plan benefits that apply to the out-of-pocket maximum are inpatient hospital care, outpatient surgery and coinsurance benefits, such as ambulance.

This summary is not a contract. It is for illustrative purposes ONLY. The contents of this form are subject to the provisions of the policy (EOC) which contains all terms, covenants and conditions of coverage.