KAISER PERMANENTE®

2012 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
HMO COPAY SOCO FY2012-13 – STATE OF COLORADO, GROUP #00225
Southern Colorado – 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: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller 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]	Not Applicable
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	a) No Deductibles b) No Deductibles 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) $1,000 per Individual per contract year b) $3,000 per Family per contract year c) Not Applicable For Families, the individual family members are responsible for meeting the Family OPM, only up to the Individual OPM amount.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	None
7A. COVERED PROVIDERS	Kaiser Permanente Southern Colorado Plan Providers See Provider Directory for a complete list of current providers

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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**	Does not apply toward Out-of-Pocket Maximum ("OPM") a) $30 Copayment each primary care office visit b) $50 Copayment each specialist care office visit 20% Coinsurance for Office Administered Drugs - Applies toward OPM Line 13 may apply for procedures performed during an office visit
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Does not apply toward OPM a) No Charge (100% covered) each visit b) No Charge (100% covered) each visit 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 No Charge (100% covered) each visit -Does not apply toward OPM b) $750 Copayment per admission - Applies toward OPM
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	Does not apply toward OPM $10 Generic/$30 Brand per prescription up to a 30-day supply, /20% Coinsurance for specialty drugs, including self-administered injectables, up to a maximum of $75 per drug dispensed Mail-order drugs available for up to a 60 or 90-day supply for two Copayments - Certain drugs limited to a 30-day supply For drugs on our approved list, please contact Southern Colorado Member Services toll-free at 1-888-681-7878 or TTY 1-800-521-4874.
12. INPATIENT HOSPITAL	Applies toward OPM $750 Copayment per admission
13. OUTPATIENT/AMBULATORY SURGERY	Applies toward OPM $150 Copayment each visit for outpatient surgery performed in any setting other than inpatient
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	Does not apply toward OPM a) Diagnostic Lab and X-ray - No Charge (100% covered) Therapeutic X-ray - $50 Copayment each visit b) MRI/CT/PET (Special Procedures)- $100 Copayment per procedure

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY **(Out-of-Network care is not covered except as noted)**
15. EMERGENCY CARE[7], [8]	Does not apply toward OPM $100 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient Line 14b procedures (Special Procedures) performed while receiving Emergency Services will generate a separate Copayment per procedure in addition to the Emergency Services Copayment. The Copayment(s) for Special Procedures is (are) waived if admitted as an inpatient.
16. AMBULANCE	Coinsurance only applies toward OPM 20% Coinsurance up to a maximum of $500 per trip
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	a) Urgent care[7] - Does not apply toward OPM $100 Copayment each visit at a Kaiser Permanente designated Plan emergency room inside the Service Area or a non-Plan emergency room outside the Service Area, waived if admitted as an inpatient b) Non-routine care - Does not apply toward OPM $30 Copayment each visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area during office hours c) After-hours care- Does not apply toward OPM $50 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area
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 -Applies toward OPM $750 Copayment per admission b) Outpatient - Coinsurance only applies toward OPM $30 Copayment each visit 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 - Applies toward OPM $750 Copayment per admission. Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation - Applies toward OPM $750 Copayment b) Outpatient Chemical Dependency - Coinsurance only applies toward OPM $30 Copayment each visit. Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar.

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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 - –Applies toward OPM $750 Copayment per admission Outpatient - Does not apply toward OPM $30 Copayment each visit for up to 20 visits per contract year for each type of therapy (i.e. physical, occupational and speech therapy) Therapy for congenital defects and birth abnormalities is 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	Does not apply toward OPM No Charge (100% covered)/ up to $5,000 annual maximum benefit paid by Health Plan per contract year Prosthetic arms and legs covered at No Charge (100% covered) 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	Does not apply toward 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.
25. HOME HEALTH CARE	Does not apply toward OPM No Charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area.
26. HOSPICE CARE	Inpatient Only Applies toward OPM No Charge (100% covered) for hospice care. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	Does not apply toward OPM No Charge (100% covered) for up to 100 days per contract year for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area.
28. DENTAL CARE	Not covered.
29. VISION CARE	Does not apply toward OPM $30 Copayment per eye wellness and refraction exams performed by an Optometrist Hardware not covered.
30. CHIROPRACTIC CARE	Does not apply toward OPM $30 Copayment, each visit up to 20 visits per contract year

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Hearing Aid credit for those age 18 and over, Pre-Hospice Special Services Hospice Program, Hearing aids for minors,, Post-mastectomy breast reconstruction, Kaiser Permanente Cancer Screening Guidelines (attached)

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. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list 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 toll-free at 1-888-681-7878 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 Toll-free 1-888-681-7878 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 ONLY (Out-of-Network care is not covered except as noted)
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 LGEOC-DENCOS (01-12) and GA-Large-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)

Breast Cancer:

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.