



2011 Colorado Health Benefit Plan Description Form
Kaiser Foundation Health Plan of Colorado
Plan ML13A OPTION 2, MAPLETON PUBLIC SCHOOLS, Group #00211
Denver/Boulder – Large 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: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, 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	Contract (Benefit) Year	Contract (Benefit) Year	Contract (Benefit) Year
4a. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	a) \$500/Individual per contract year b) \$1,500/Family per contract year	a) \$500/Individual per contract year b) \$1,500/Family per contract year	a) \$1,000/Individual per contract year b) \$3,000/Family per contract 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. 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 MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	a) \$1,500/Individual per contract year b) \$4,500/Family per contract year c) No	a) \$1,500/Individual per contract year b) \$4,500/Family per contract year c) No	a) \$4,000/Individual per contract year b) \$12,000/Family per contract year c) No, the Out-of-Pocket Maximum (“OPM”) excludes Deductible and Copayments
	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	<u>None</u>	\$1,000,000 per Individual Combined Maximum Benefit while insured	
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See online provider directory for complete list 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	Not subject to the Deductible; does not apply to the OPM a) \$30 Copayment each primary care office visit, b) \$40 Copayment each specialist care office visit, 10% Coinsurance for procedures received during an office visit, (including Office Administered Drugs), after Deductible is met. (Note: Procedures received during an office visit (including Office Administered Drugs) are Subject to the Deductible; does apply to the OPM)	Not subject to the Deductible; does not apply to the OPM a) \$30 Copayment each primary care office visit b) \$40 Copayment each specialist care office visit Only Diagnostic Lab and X-ray performed in a physician's office are included in the office visit Copayment. 10% Coinsurance applies after Deductible for all other services. (Note: Procedures received during an office visit are Subject to the Deductible; does apply to the OPM)	Subject to Deductible; applies toward OPM a) 30% Coinsurance after Deductible is met b) 30% Coinsurance after Deductible is met
	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
9. PREVENTIVE CARE a) Children's services b) Adults' services	Not subject to the Deductible; does not apply to the OPM a) No Charge (100% covered), b) No Charge (100% covered), The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance shown above	Not subject to the Deductible; does not apply to the OPM a) No Charge (100% covered) each visit b) No Charge (100% covered) each visit Limited adult services available The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance listed above	Not subject to Deductible; Does not apply toward OPM a) \$70 per visit copay b) \$70 per visit copay Limited adult services available 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 care⁵	a) Routine Prenatal Care Not subject to the Deductible; does not apply to the OPM No Charge (100% covered) each visit, 10% Coinsurance for procedures received during an office visit after Deductible is met (Note: procedures received during an office visit are Subject to the Deductible; does apply to the OPM) b) Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met	a) Routine Prenatal Care Not subject to the Deductible; does not apply to the OPM No Charge (100% covered) each visit 10% Coinsurance for procedures received during an office visit, after Deductible is met (Note: procedures received during an office visit are Subject to the Deductible; does apply to the OPM) b) Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met.	a) Routine Prenatal Care - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. b) Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met.

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions.	Not subject to the Deductible; does not apply to the OPM \$20 generic/\$35 brand (preferred) /50% Coinsurance (non-preferred) per prescription /20% Coinsurance for specialty drugs, including self-injectables up to a 30-day supply. Mail-order drugs available for up to a 90-day supply for two Copayments - Certain drugs limited to a 30-day supply Drugs must be purchased through Kaiser Permanente pharmacies. For drugs on our approved list, please contact your Clinical Pharmacy Call Center at 1-866-244-4119 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874.	Not subject to the Deductible; does not apply to the OPM \$25 preferred generic/\$40 preferred brand copay 50% Coinsurance (non-preferred) 20% Coinsurance for specialty drugs, including self-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. Preferred drug status for individual drugs may vary between Kaiser Permanente formulary and the MedImpact Preferred Drug List.	
	Note: The Pharmacy Deductible, if applicable, is not subject to the Deductible and does not apply to the OPM		
12. INPATIENT HOSPITAL	Subject to the Deductible; does apply to the OPM 10% Coinsurance, after Deductible is met. 10% Coinsurance for inpatient professional visits, after Deductible is met.	Subject to the Deductible; does apply to the OPM 10% Coinsurance, after Deductible is met Precertification required. 10% Coinsurance for inpatient professional visits, after Deductible is met.	Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. Precertification required. 30% Coinsurance for inpatient professional visits, after Deductible is met.
13. OUTPATIENT/AMBULATORY SURGERY	Subject to the Deductible; does apply to the OPM 10% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met	Subject to the Deductible; does apply to the OPM 10% Coinsurance for outpatient surgery performed in any setting other than inpatient, after after Deductible is met. Precertification required.	Subject to Deductible; applies toward OPM 30% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met. Precertification required.

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, and other high-tech services	a) <u>Diagnostic Lab</u> – Not subject to the Deductible; does not apply to the OPM No Charge (100% covered) for laboratory services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) 10% Coinsurance for laboratory services in the outpatient department of a Plan Hospital after Deductible is met (Note: laboratory services in the outpatient department of a Plan Hospital are subject to the Deductible, do apply to the OPM) <u>Diagnostic X-ray, including Therapeutic</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met b) <u>MRI/CT/PET</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met	a) Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met b) Subject to the Deductible; does apply to the OPM 10% Coinsurance after Deductible is met. Precertification required for MRI/CT/PET.	a) Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. b) Subject to Deductible; applies toward OPM 30% 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 the Deductible; does apply to the 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	
16. AMBULANCE	Not subject to the Deductible; does not apply to the OPM 10% Coinsurance up to \$500 per trip,	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
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	<p>a) <u>Urgent care</u>⁷ - Subject to the Deductible; does apply to the OPM</p> <p>10% Coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after Deductible is met</p> <p>b) <u>Non-routine care</u> - Not subject to the Deductible; does not apply to the OPM</p> <p>\$30 Copayment at a Kaiser Permanente designated Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area, during office hours;</p> <p>10% Coinsurance for procedures received during the visit, after Deductible is met. (Note: Procedures received during the visit are Subject to the Deductible; does apply to the OPM)</p> <p>c) <u>After-hours care</u> - Not subject to the Deductible; does not apply to the OPM</p> <p>\$40 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 the Deductible; does apply to the OPM)</p>	<p>a) <u>Urgent care</u>⁷ - Subject to the Deductible; does apply to the OPM</p> <p>10% Coinsurance at a participating provider Urgent care facility, , after Deductible is met</p> <p>Emergency Room Care covered as IN-NETWORK benefit</p> <p>b) <u>Non-routine care</u> - Not subject to the Deductible; does not apply to the OPM</p> <p>\$30 Copayment during normal office hours at a PREFERRED PROVIDER medical office</p> <p>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) Subject to the Deductible; does apply to the OPM)</p> <p>c) <u>After-hours care</u> - Not subject to the Deductible; does not apply to the OPM</p> <p>\$40 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 Subject to the Deductible; does apply to the OPM)</p>	<p>a) <u>Urgent care</u>⁷ - 30% Coinsurance at a non-participating provider emergency room outside the Service Area, after Deductible is met</p> <p>Emergency Room Care covered as IN-NETWORK benefit</p> <p>b) <u>Non-routine care</u> - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible, each visit at an OUT-OF-NETWORK medical office</p> <p>c) <u>After-hours care</u> - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met, each after-hours visit at an OUT-OF-NETWORK medical office</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	See Box 19, below		
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) <u>Inpatient</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance, after Deductible is met	a) <u>Inpatient</u> - Subject to the Deductible; does apply to the OPM 10% Coinsurance, after Deductible is met Pre-certification required.	a) <u>Inpatient</u> - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met
	b) <u>Outpatient</u> – Not subject to the Deductible; does not apply to the OPM \$30 Copayment 10% Coinsurance for inpatient professional visits, after Deductible is met. (Note: inpatient professional visit are Subject to the Deductible; does apply to the OPM)	b) <u>Outpatient</u> -- Not subject to the Deductible; does not apply to the OPM \$30 Copayment 10% Coinsurancefor inpatient professional visits, after Deductible is met. (Note: inpatient professional visit are Subject to the Deductible; does apply to the OPM)	b) <u>Outpatient</u> – Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met
20. ALCOHOL & SUBSTANCE ABUSE	a) <u>Inpatient Medical Detoxification</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance per admission, after Deductible is met. Detoxification is limited to removing toxic substance from the body <u>Inpatient Residential Rehabilitation</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance per admission, after Deductible is met	a) <u>Inpatient Medical Detoxification</u> – Subject to the Deductible; does apply to the OPM 10% Coinsurance per admission, after Deductible is met. Detoxification is limited to removing toxic substance from the body <u>Inpatient Residential Rehabilitation</u> - Subject to the Deductible; does apply to the OPM 10% Coinsurance, after Deductible is met Pre-certification required.	a) <u>Inpatient Medical Detoxification</u> – 30% Coinsurance after Deductible is met <u>Inpatient Residential Rehabilitation</u> - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. Pre-certification required.
	b) <u>Outpatient Chemical Dependency</u> – Not subject to the Deductible; does not apply to the OPM \$30 Copayment each visit 10% Coinsurance for inpatient professional visits, after Deductible is met. (Note: inpatient professional visits are Subject to the Deductible; does apply to the OPM)	b) <u>Outpatient Chemical Dependency</u> – Not subject to the Deductible; does not apply to the OPM \$30 Copayment each visit 10% Coinsurance for inpatient professional visits, after Deductible is met. (Note: inpatient professional visits are Subject to the Deductible; does apply to the OPM)	b) <u>Outpatient Chemical Dependency</u> – 30% Coinsurance after Deductible is met

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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 (2) months		
	<p><u>Inpatient</u>* – Subject to the Deductible; does apply to the OPM</p> <p>10% Coinsurance, after Deductible is met</p> <p><u>Outpatient</u>* – Not subject to the Deductible; does not apply to the OPM</p> <p>\$30 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 the Deductible; does not apply to the OPM</p> <p>\$30 Copayment each visit for up to 20 visits per year for each type of therapy (i.e. physical, occupational and speech therapy)</p>	<p><u>Inpatient</u>* - Benefits covered IN-NETWORK only</p> <p><u>Outpatient</u>* - Subject to Deductible; applies toward OPM</p> <p>30% Coinsurance after Deductible is met</p>
	<p>*Limited to a combined (PREFERRED PROVIDER NETWORK and OUT-OF-NETWORK) maximum of 20 visits per calendar year for conditions subject to improvement within two months. Limited to a combined maximum of 20 visits per therapy per calendar year for both acute and chronic conditions for children with congenital defects and birth abnormalities from age 3 to age 6. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services.</p>		
Therapies for the treatment of autism spectrum disorders are not subject to any visit limits and include long term rehabilitation.			
22. DURABLE MEDICAL EQUIPMENT	<p>Not subject to the Deductible; does not apply to the OPM</p> <p>10% Coinsurance within the Service Area, - \$2,000 annual benefit maximum per contract year. Prosthetic arms and legs covered at 10% Coinsurance with no annual maximum. See policy for types and circumstances of coverage.</p>	<p>Subject to Deductible; applies toward OPM</p> <p>Prosthetic replacement of arms or legs covered at 20% Coinsurance after PREFERRED PROVIDER NETWORK deductible with no annual maximum.</p>	<p>Subject to Deductible; applies toward OPM</p> <p>Prosthetic replacement of arms or legs covered at 20% Coinsurance after OUT-OF-NETWORK Deductible with no annual maximum. .</p>
	All other DME orders must be obtained IN-NETWORK.		
23. OXYGEN	<p>Not subject to the Deductible; does not apply to the OPM</p> <p>10% Coinsurance</p>	Benefit 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	For inpatient, see Box 12, Inpatient Hospital.. For 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.	Benefits covered IN-NETWORK only	
25. HOME HEALTH CARE	Subject to the Deductible; does apply to the OPM 10% Coinsurance for prescribed medically necessary part-time home health services, after Deductible is met. Not covered outside the Service Area.	Subject to the Deductible; does apply to the OPM Combined maximum of 60 home health visits per calendar year	
		10% Coinsurance after Deductible is met.	30% Coinsurance after Deductible is met
26. HOSPICE CARE	Subject to the Deductible; does apply to the OPM 10% Coinsurance for hospice care, after Deductible is met. Not covered outside the Service Area.	Subject to the Deductible; does apply to the 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	30% Coinsurance after Deductible is met
27. SKILLED NURSING FACILITY CARE	Subject to the Deductible; does apply to the OPM 10% Coinsurance for up to 100 days per contract year for prescribed skilled nursing facility services at approved skilled nursing facilities, after Deductible is met. Not covered outside the Service Area.	Benefits covered IN-NETWORK only	
28. DENTAL CARE	Not Covered		

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
29. VISION CARE	Not subject to the Deductible; does not apply to the OPM \$30 Copayment each visit for eye wellness and refraction exams performed by an Optometrist., \$150 credit toward lenses, frames or contacts every two years	Benefits covered IN-NETWORK only	
30. CHIROPRACTIC CARE	Not subject to the Deductible; does not apply to the OPM \$30 Copayment each visit for up to 20 visits per contract year,	Not subject to the Deductible; does not apply to the OPM toward OPM \$30 Copayment each visit - Maximum of 20 visits per contract year. Limited to manual manipulation of the spine only	Not Covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Pre-Hospice Special Services Hospice Program, Travel Clinic-pretravel assessment/prescription, Post-mastectomy breast reconstruction, Hearing aids for minors	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	
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.		

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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 toll-free 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 Denver, 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		
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 LG -DHMO-EOC-DENCOS(01-11), POS Amend (01-10) and GA-DENCOS(01-11) Large Group	Policy forms KPIC-GC-POS-LG-2011-CO Large Group	
43. Does the plan have a binding arbitration clause?	Yes	No	

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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 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.