



2008 Preliminary Colorado Health Benefit Plan Description Form Disclaimer

This is a 2008 Preliminary Colorado Health Benefit Plan Description Form. It does not include changes that may occur throughout the remainder of the year including, but not limited to, mandated federal or state changes. Any additional benefit changes or clarifications will be provided in the 2008 Colorado Health Benefit Plan Description Form.

NOTE: To the extent this 2008 Preliminary Colorado Health Benefit Plan Description Form conflicts with, modifies or supplements the information contained in the 2008 Colorado Health Benefit Plan Description Form, the information contained in the 2008 Colorado Health Benefit Plan Description Form shall supersede what is set forth in the 2008 Preliminary Colorado Health Benefit Plan Description Form.



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**Kaiser Foundation Health Plan of Colorado
Plan 420P – JEFFERSON CENTER MENTAL HEALTH
Denver/Boulder – 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: 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 ONLY (Out-of-Network care is not covered except as noted)
4. Deductible Type²	Not Applicable
4a. ANNUAL DEDUCTIBLE^{2a} a) Individual ^{2b} b) Family ^{2c}	a) No Deductibles b) No Deductibles 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 per Individual per calendar year b) \$4,500 per Family per calendar year c) Not Applicable
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	<u>Lifetime Maximum</u> No Lifetime Maximum The Lifetime Maximum represents the combined benefit maximum for all covered services. <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 towards the Transplant Lifetime Maximum or the Lifetime Maximum.
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See Provider Directory for a complete list of current providers
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	a) \$20 Copayment each primary care office visit b) \$30 Copayment each specialist care office visit Line 13 may apply for procedures performed during an office visit
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) \$10 Copayment each visit b) \$10 Copayment each visit
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	a) \$10 Copayment each visit b) \$500 Copayment per admission
11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions	\$15 Generic/\$25 Brand per prescription up to a 60-day supply. (Drugs may be ordered by mail) - Certain drugs 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 . Note: The Pharmacy Deductible, if applicable, does not apply towards the OPM.
12. INPATIENT HOSPITAL	\$500 Copayment per admission
13. OUTPATIENT/AMBULATORY SURGERY	\$100 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	a) <u>Diagnostic Lab and X-ray</u> - No Charge (100% covered) <u>Therapeutic X-ray</u> - \$30 Copayment each visit b) <u>MRI/CT/PET</u> - \$100 Copayment per procedure
15. EMERGENCY CARE^{7, 8}	\$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	20% Coinsurance up to a maximum of \$500 per trip

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	<p>a) <u>Urgent care</u>⁷ \$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</p> <p>b) <u>Non-routine care</u> \$20 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</p> <p>c) <u>After-hours care</u> \$50 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area</p>
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) <u>Inpatient care</u> b) <u>Outpatient care</u>	<p>a) <u>Inpatient</u> - \$500 Copayment per admission - up to 45 days per calendar year</p> <p>b) <u>Outpatient</u> - \$20 Copayment each visit up to 20 visits per calendar year. Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar. Two (2) group visits will count as one individual visit.</p>
20. ALCOHOL & SUBSTANCE ABUSE	<p>a) <u>Inpatient Medical Detoxification</u> - \$500 Copayment per admission. Detoxification is limited to removing toxic substance from the body <u>Inpatient Residential Rehabilitation</u> - \$500 Copayment per admission up to 30 days per calendar year</p> <p>b) <u>Outpatient Chemical Dependency</u> - \$20 Copayment each visit up to 20 visits per calendar year. Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.</p>
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	<p>For conditions subject to significant improvement within two (2) months</p> <p>*<u>Inpatient</u> - \$500 Copayment per admission</p> <p>*<u>Outpatient</u> - \$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 up to age five (5) for both acute and chronic conditions</p>
22. DURABLE MEDICAL EQUIPMENT	<p>20% Coinsurance/ up to \$2,000 annual maximum benefit paid by Health Plan per contract year</p> <p>Prosthetic arms and legs covered at 20% Coinsurance with no annual maximum benefit. See policy for types and circumstances of coverage</p>
23. OXYGEN	20% Coinsurance
24. ORGAN TRANSPLANTS	No Charge (100% covered) for transplant. Applicable inpatient and outpatient charges apply — 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.
25. HOME HEALTH CARE	No Charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area.

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
26. HOSPICE CARE	No Charge (100% covered) for hospice care. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	No Charge (100% covered) for up to 100 days per calendar 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	\$20 Copayment per vision (refraction) exam performed by an Optometrist. Hardware not covered.
30. CHIROPRACTIC CARE	\$20 copay, each visit up to 20 visits per calendar year
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; 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; Limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area

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 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
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 at 303-338-3800 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874

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PART D: USING THE PLAN CONTINUED

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
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 LGEOC-DENCOS(01-08) and GA-Large-DENCOS(01-08) Large Group <i>(Will be available by January 1, 2008)</i>
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.

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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	Unlimited	As jointly determined by physician and patient
Mammogram	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	Unlimited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician
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.