KAISER PERMANENTE®

2002 Colorado Health Plan Description Form
Kaiser Foundation Health Plan of Colorado
Plan 215 – Burlinton Northern Santa Fe, Group # 7522

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, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties.

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.

	IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)
4. ANNUAL DEDUCTIBLE a) Individual b) Family	 No Deductibles No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM[2] a) Individual b) Family	 $2,000/Individual $4,500/Family
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See Provider Directory for complete list
7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?	Not applicable. This is not a network plan
8. ROUTINE MEDICAL OFFICE VISITS	$15 per visit copay
9. PREVENTIVE CARE a) Children's services b) Adults' services	 $15 per visit copay $15 per visit copay
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care	 $15 per visit copay No copay (100% covered)
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	 $10 generic/$15 brand up to a 60-day supply Certain drugs are limited to a 30-day supply For drugs on our approved list, please contact your Medical Office Pharmacist
12. INPATIENT HOSPITAL	No copay (100% covered)
13. OUTPATIENT/AMBULATORY SURGERY	$50 per visit copay
14. LABORATORY & X-RAY	Diagnostic Lab and X-ray - No copay (100% covered) Therapeutic X-ray - $15 per visit copay
15. EMERGENCY CARE[3]	$50 per visit copay at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual reasonable and customary charges.
16. AMBULANCE	$50 copay per incident
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 per visit copay at a designated Kaiser Permanente emergency room $15 per visit copay at a Kaiser Permanente medical office during office hours. $25 per visit after hours copay at designated Kaiser Permanente medical offices

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK ONLY
18. BIOLOGICALLY-BASED MENTAL ILLNESS[4] CARE	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	Inpatient - No copay (100% Covered) per admission up to 45 days each calendar year Outpatient - $15 copay each visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient b) Outpatient	Inpatient Medical Detoxification - No copay (100% covered) Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation - No copay (100% Covered) per admission up to 45 days each calendar year Outpatient Chemical Dependency - $15 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	*Inpatient No copay (100% covered) for conditions subject to significant improvement within two months *Outpatient - $15 per visit copay for up to two months per condition, or up to 20 visits per condition if 20 or more visits are not received within two months, for conditions subject to significant improvement within two months *Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions.
22. DURABLE MEDICAL EQUIPMENT	No copay (100% covered) within the Service Area. $2,000 annual benefit maximum per contract year. Prosthetic arms and legs covered at 20% copay with no annual maximum See policy for types and circumstances of coverage
23. OXYGEN	No copay (100% covered)
24. ORGAN TRANSPLANTS	No copay (100% covered) - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver
25. HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area
26. HOSPICE CARE	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area.
27. SKILLED NURSING FACILITY CARE	No copay (100% covered) for up to 100 days for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area
28. DENTAL CARE	No dental benefits are available
29. VISION CARE	$15 per visit copay for vision exam Hardware not covered
30. CHIROPRACTIC CARE	No chiropractic benefits are available
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses and services due to complications; 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

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PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK ONLY
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]	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. 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

PART D: USING THE PLAN

	IN-NETWORK ONLY
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
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?	(303) 338-3800
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 Telephone (303) 338-3800
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filling 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 form SA215-DEN(01-01) Large Group *(2002 materials are not yet filed.)*

PART E: COST

	IN-NETWORK ONLY
43. What is the cost of this plan?	Contact your agent, this insurance company, or your employer, as appropriate to find out the premium for this plan. In some cases, plan costs are included with this form

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PART F: PHYSICIAN PAYMENT METHODS AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINSTRATION AND PROFIT

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions below. The request may be orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment of primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

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] "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

[3] "Emergency care" means services delivered by an emergency care facility which 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.

[4] "Biologically based mental illnesses" means schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5] 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.

[6] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

