

Kaiser FHP of Colorado - New Plan Design



State: CO

Benefits 2009

		In-Network Coverage	
Plan facts	Member services	(800) 632-9700	Annual enrollment information: (800) 632-9700
	Member services hours	Mon-Fri: 8:00 AM-5:00 PM MT	
	Web address	http://my.kp.org/citigroup	
	Product name	Kaiser Permanente	
Your medical expenses	Annual deductible	\$100 (individual) / \$200 (family max)*	
	Out-of-pocket maximum (includes deductible)	\$2,000 (individual) / \$4,000 (family max) per calendar year*	
	Office visits	Covered at 90% after deductible*	
	Maternity care prenatal office visits	Covered at 90% after deductible*	
	Inpatient hospitalization	Covered at 90% after deductible*	
	Outpatient surgical care	Covered at 90% after deductible*	
	Outpatient lab and X-ray	Covered at 90% after deductible*	
	Emergency room care	Covered at 90% after deductible*	
	Urgent care facility	Covered at 90% after deductible*	
Your prescription drug expenses	Retail	\$10 copay (generic), \$20 copay (brand name), \$40 copay (non-preferred brand) per prescription up to 30-day supply*	
	Mail order	\$20 copay (generic), \$40 copay (brand name), \$80 copay (non-preferred brand) per prescription up to 90-day supply*	
Preventive care	Routine physical and GYN exam	Covered at 100%, no deductible*	
	Routine vision exam	Covered at 100%, no deductible*	
	Well-child care and immunizations	Covered at 100%, no deductible*	
	Routine mammography	Covered at 100%, no deductible*	
Mental health	Inpatient	Covered at 90% after deductible. Limit 45 days per calendar year*	
	Outpatient	Covered at 90% after deductible. Limit 20 visits per calendar year*	
Substance abuse	Inpatient detoxification	Covered at 90% after deductible. Limit 30 days per calendar year*	
	Inpatient rehabilitation	Covered at 90% after deductible. Limit 30 days per calendar year*	
	Outpatient detoxification	Covered at 90% after deductible. Limit 20 visits per calendar year*	
	Outpatient rehabilitation	Covered at 90% after deductible. Limit 20 visits per calendar year*	
Other professional care	Outpatient physical/speech/occupational therapy	Covered at 90% after deductible. Limit 20 visits per calendar year*	
	Chiropractic care	\$15 copay per visit. Limit 20 visits per year	
	Infertility	Diagnosis/Treatment/Artificial Insemination: Covered at 50%. Contact plan for details	
Out-of-network coverage	Out-of-network non-emergency care	Not covered	
Key facts	NCQA status:	Excellent	Domestic partner coverage available: Yes
	PCP referral required for specialist:	No	Domestic partner children coverage avail.: Yes
	Lifetime maximum benefit:	NA	
	Provider network:	See website for details	

* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.