Kaiser FHP of Colorado

State: CO

citi **Benefits 2011**

		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	$500 (individual) / $1,000 (family max)
	Out-of-pocket maximum (includes deductible)	$3,000 (individual) / $6,000 (family max) per calendar year
	Office visits	Covered at 90% after deductible
	Maternity care prenatal office visits	Covered at 100% 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	$100 copay/visit (waived if admitted)
	Urgent care facility	Covered at 90% after deductible. Out-of-area: Not covered*
Your prescription drug expenses	Retail	$10 copay (generic), $20 copay (preferred brand), $40 copay (non-preferred brand) per prescription up to 30-day supply
	Mail order	$20 copay (generic), $40 copay (preferred brand name), $80 copay (non-preferred brand name) per prescription up to 90-day supply
Preventive care	Routine physical and GYN exam	Routine Physical: Covered at 100%, no deductible. GYN: Annual visit covered at 100%, thereafter covered at 90%
	Routine vision exam	Covered at 100%, no deductible. Services provided by optometrist covered at 90% after 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
	Outpatient	Covered at 90% after deductible
Substance abuse	Inpatient detoxification	Covered at 90% after deductible
	Inpatient rehabilitation	Covered at 90% after deductible
	Outpatient detoxification	Covered at 90% after deductible
	Outpatient rehabilitation	Covered at 90% after deductible
Other professional care	Outpatient physical/speech/ occupational therapy	Covered at 90% after deductible. Limit 20 visits per therapy per calendar year
	Chiropractic care	$15 copay per visit. Limit 20 visits per year
	Infertility	Diagnosis/Treatment/Artificial Insemination: Covered at 50%. In vitro fertilization not covered. Contact Plan for details*
Out-of-network coverage	Out-of-network non-emergency care	Out-of-area student benefit for routine care. Contact Plan for details
Key facts	NCQA status:	Excellent
	PCP referral required for specialist:	No
	Lifetime maximum benefit:	NA
	Provider network:	See website for details
	Domestic partner coverage available:	Yes
	Domestic partner children coverage available:	Yes

*** Indicates a benefit change**

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