Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2022 In-Network**	**Comments**
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	100% after applicable copay	
Precertification Requirements	None	
Precertification Penalty	None	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles		
Individual Annual Deductible	None	
Family Annual Deductible	None	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	N/A	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	$3,000.00	
Family Out-of-Pocket Maximum Per Year	$6,000.00	
Outpatient Services		
Primary Care Physician Visits	$20 per visit	
Specialist Visit	$35 per visit	
Lab tests and X-ray	No charge/ $35 per encounter $20 office visit copay may apply.	
Specialized Imaging	$100 Copay	
Outpatient Surgery	Outpatient Surgery Center: $100 per procedure; PCP Office: $20 per procedure	
Allergy Testing	$35 per visit	
Allergy Injections	No charge; office visit copay may apply	
Preventive Care		
Well Child Care Office Visit	100% covered	
Well Child Age limit	23 months	
Adult Routine Physical Exams	100% covered	
Adult Immunizations	No charge; office visit copay may apply	
Routine Mammogram	No charge	
Pap Smear	100% covered	
Prostate Screening (PSA)	100% covered	
Colon Cancer Screenings	100% covered	
Cardiovascular screenings	100% covered	
Hearing Evaluations	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay	
Inpatient Hospital		
Deductible per Confinement	None	
Deductible per Day	None	
Hospital Services	No charge	
Physicians and Surgeons' Services	No charge	
Emergency Services		
Emergency Room Treatment	$75.00	
Non-emergency or non-urgent use of ER	Not covered	
Ambulance	$25.00	
Urgent Care Facility Services	$20 per visit	
Physician Office Visit	Included in $75 ER Copay	
After Hours	$20 per Urgent Care visit,$75 ER visit	
Maternity Care		
Physician Office Visit	No charge	
Maternity Care - Inpatient Delivery	No charge	
Midwife delivery services	No charge; at facilities where available	

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Mental Health		
Deductible per Confinement	None	
Deductible per Day	None	
Mental Health Inpatient	No charge	
Mental Health-Inpatient Plan Maximums	None	
Mental Health Outpatient	$20 per individual visit	
Mental Health - Group Therapy	$10 per group visit	
Mental Health-Outpatient Plan Maximums	None	
Severe Mental Illness	No charge for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit; no day or visit limits. 190 Lifetime days	
Substance Abuse		
Deductible per Confinement	None	
Deductible per Day	None	
Detoxification	No charge	
Substance Abuse - Inpatient Treatment	No charge for Transitional Residential Recovery Services (TRRS) in a non-medical setting	
Substance Abuse-Inpatient Plan Maximums	Limited to detox only Transitional Residential Recovery Services provided at no charge and with no day limits, in compliance with MHPA, as long as medically necessary and prescribed by a Plan physician	
Substance Abuse-Outpatient	$20 per individual visit; $10 per group visit	
Substance Abuse-Outpatient Plan Maximums	Unlimited	
Rehabilitation Therapy		
Inpatient Rehabilitation	No charge	
Outpatient Physical, Occupational, and Speech Therapy	$20 copay per visit. Benefits limited to medically necessary therapy authorized by a Plan physician.	
Alternative Care		
Chiropractic Care	$20 per visit, up to 20 visits per calendar year with American Specialty Health Plans rider	
Acupuncture	N/A	
Acupressure	Not covered	
Massage Therapy	Not covered	
Other Services		
Private-Duty Nursing Care	No charge when medically necessary and authorized by a Plan physician for inpatient care	
Durable Medical Equipment	No charge when prescribed by a Plan physician in accordance with Formulary guidelines	
Prosthetic and Orthotic Appliances	No charge when prescribed by a Plan physician in accordance with Formulary guidelines	
Smoking Cessation	No charge when prescribed by a Plan physician in accordance with Formulary guidelines	
Weight control program	Covered health education classes are at no charge	
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization	
TMJ	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization	
Podiatry Services	$35 per visit when medically necessary	
Home Health Care	No charge when prescribed by a Plan physician; limited to 2 hours/visit, 3 visits/day, 100 visits per year	
Skilled Nursing Facility Care	No charge, up to 100 days per benefit period	
Hospice Care	No charge when authorized by a Plan physician for a terminal diagnosis with life expectancy of less than one year	
Hearing Aids	Covered up to age 18	

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Family Planning		
Tubal ligation	No charge; after appropriate counseling	
Vasectomy	$100 copay (outpatient); No charge (inpatient); after appropriate counseling	
Contraceptive Drugs	100% covered	
Contraceptive Devices	100% covered	
Infertility Testing	$35 per visit; no charge for lab	
Infertility Treatments - Office Visit	$35 per visit	
Infertility Treatments - Surgery	Specialist office: $35 per procedure; Outpatient Surgery Center: $100 per procedure; Inpatient: No charge	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Treatment for involuntary infertility is covered as authorized by a Plan physician	
Vision Care		
Eye Examination	Preventive: 100% covered; PCP Diagnostic: $20 copay; Specialist Diagnostic: $35 copay	
Lenses	Not covered	
Frames	Not covered	
Contact lenses- necessary	When prescribed by a Plan physician, no charge for contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months. When prescribed by a Plan physician for aphakia (absence of the crystalline lens of the eye), no charge for up to 6 lenses per eye every 12 months, through age 9	
Contact lenses-elective	Not covered	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	No charge for inpatient	
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary	
Transplant Travel	Covered when pre-authorized by the Plan physician and related to the provision of covered services, in accordance with Plan policies	
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant	
Lifetime Maximum	None	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	None	
Annual Prescription Deductible - Individual	None	
Out-of-Pocket Maximums - Individual	N/A	
Out-of-Pocket Maximums - Family	N/A	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Generic Substitution	Determined by patient's Plan physician	
Retail Refill Penalty	None	
Prescription Drug Retail		
Retail - Generic	$10 per prescription, up to a 30-day supply All prescriptions must be medically necessary, prescribed by a Plan physician, and obtained from a Plan pharmacy of from Plan mail order to be covered	
Retail - Brand Formulary	$30 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Retail - Brand Non-Formulary	$30 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Single Source Brand	$30 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Multi Source Brand	$30 per prescription; up to 30-day supply; when medically necessary, prescribed by a Plan physician, and filled at Plan pharmacies	
Injectable Medications	$10 per generic/$30 per brand prescription, up to a 30-day supply	

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Prescription Drug Mail Order		
Mail-Order - Generic	$10 for up to a 30-day supply, or $20 for a 31 to 100-day supply	Specialty RX 20% Coinsurance up to a maximum of $25
Mail-Order - Brand Formulary	$30 for up to 30-day supply; $60 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	Specialty RX 20% Coinsurance up to a maximum of $25
Mail-Order - Brand Non-Formulary	$30 for up to 30-day supply; $60 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	Specialty RX 20% Coinsurance up to a maximum of $25
Single Source Brand	$30 for up to 30-day supply; $60 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	Specialty RX 20% Coinsurance up to a maximum of $25
Multi Source Brand	$30 for up to 30-day supply; $60 for a 31- day up to a 100-day supply; when medically necessary, prescribed by a Plan physician and filled at Plan mail order	Specialty RX 20% Coinsurance up to a maximum of $25
Injectable Medications	$10 Generic/$30 brand for up to a 30-day supply, or $20 generic/$60 brand for a 31- to 100-day supply	
Day Supply	Up to 100	
Other Services - Prescription Drugs		
Over the Counter	Not covered	
Prenatal Vitamins	Not covered	
Diabetic Supplies	Insulin: $10 copay for up to 100-day supply; Testing supplies: 100% covered up to 100-day supply in accordance with DME base formulary guidelines	
Lifestyle Drugs	Drugs for the treatment of sexual dysfunction are covered at 50% of charges with a maximum dosage limit of 8 doses for 30-day supply or 27 doses for 100-day supply	
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices	
Fertility Drugs	Covered at applicable prescription copay	
Smoking Cessation	Covered at applicable prescription copay if prescribed by a Plan physician and patient is concurrently participating in a Plan-approved behavioral modification program	
Cosmetic Medications	Not covered	
Nutritional Supplements	Not covered	