Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2024 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	
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	**X-ray: Diagnostic No charge/ Therapeutic $35 per encounter; $20 office visit copay may apply. Lab: No charge.**	
Specialized Imaging	$100 Copay	
Outpatient Surgery	Outpatient Surgery Center: $100 per procedure	
Allergy Testing	$35 per visit	
Allergy Injections	office visit copay. Additional charge may apply for allergy serum	
Preventive Care		
Well Child Care Office Visit	100% covered	
Well Child Age limit	Age 0-17	Age 0-17 years old
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 per trip	
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	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2024 In-Network**	**Comments**
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	
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	
Substance Abuse-Outpatient	$20 per individual visit; $10 per group visit	
Substance Abuse-Outpatient Plan Maximums	Unlimited	
Rehabilitation Therapy		
Inpatient Rehabilitation	No charge; up to 60 days per condition per accumulation period	
Outpatient Physical, Occupational, and Speech Therapy	**$20 copay per visit, up to 20 visits per therapy per calendar year. 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**	
Acupuncture	Not covered	
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; may have copay	
Bariatric surgery	50% coinsurance if medically necessary	50.00%
TMJ	The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.	
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 6 months or less	
Hearing Aids	Covered up to age 18	

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Plan Changes are in Orange	**2024 In-Network**	**Comments**
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	**Covered at applicable visit cost share**	
Infertility Treatments - Office Visit	**Covered at applicable visit cost share**	
Infertility Treatments - Surgery	**$100 copay per encounter**	
In Vitro Fertilization	**$100 copay per encounter**	
Infertility Treatments - Lifetime Maximum	**Unlimited**	
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	Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in “Access to Other Providers” in the “How to Access Your Services and Obtain Approval of Benefits” section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines	
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	Through special exception process; $30 per prescription; up to 30 day supply if approved.	
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 Specialty 20% Coinsurance up to $250 per drug dispensed	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2024 In-Network**	**Comments**
Prescription Drug Mail Order		
Mail-Order - Generic	$20 Generic up to 90 days	**Specialty RX 20% Coinsurance up to a maximum of $250**
Mail-Order - Brand Formulary	$60 Brand up to 90 days	**Specialty RX 20% Coinsurance up to a maximum of $250**
Mail-Order - Brand Non-Formulary	**Through special exception process; $60 per prescription; up to 90 day supply if approved.**	**Specialty RX 20% Coinsurance up to a maximum of $250**
Single Source Brand	**$60 Brand up to 90 days; when medically necessary, prescribed by a Plan physician and filled at Plan mail order**	**Specialty RX 20% Coinsurance up to a maximum of $250**
Multi Source Brand	**$60 Brand up to 90 days; when medically necessary, prescribed by a Plan physician and filled at Plan mail order**	**Specialty RX 20% Coinsurance up to a maximum of $250**
Injectable Medications	$10 Generic/$30 brand for up to a 30-day supply, or $20 generic/$60 brand for a 90 day supply. Specialty 20% coinsurance up to $250 per drug dispensed	
Day Supply	30 days Mail order up to 90 days	
Other Services - Prescription Drugs		
Over the Counter	Not covered	
Prenatal Vitamins	Not covered	
Diabetic Supplies	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply of all prescription insulin drugs Diabetic Supplies - 20% Coinsurance	
Lifestyle Drugs	Not covered	
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices	
Fertility Drugs	**Covered at applicable pharmacy drug cost share.**	
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	

Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Colorado
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Plan Changes are in Orange	**2024 In-Network**
General Information	
Lifetime Maximum Benefit	None
Annual Maximum Benefit	None
Coinsurance Percentage	None
Precertification Requirements	N/A
Precertification Penalty	N/A
Health Savings Account (HSA)	N/A
Health Reimbursement Account (HRA)	N/A
R & C	None
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	Only individual OOPM applies
Outpatient Services	
Primary Care Physician Visits	$20 per visit
Specialist Visit	$35 per visit
Lab tests and X-ray	Lab no charge, diagnostic xray no charge and therapeutic $20/$35
Specialized Imaging	$100 per procedure per body part
Outpatient Surgery	$100 copay
Allergy Testing	$20/35
Allergy Injections	$20 copay each visit
Preventive Care	
Well Child Care Office Visit	No charge up to 18 years old
Well Child Age limit	No charge up to 18 years old
Adult Routine Physical Exams	No charge for medically appropriate preventive care
Adult Immunizations	No charge for pneumonia, influenza, Hep B, covid-19
Routine Mammogram	No charge
Pap Smear	No charge
Prostate Screening (PSA)	No charge
Colon Cancer Screenings	No charge
Cardiovascular screenings	No charge
Hearing Evaluations	$20 copayment each visit
Inpatient Hospital	
Deductible per Confinement	None
Deductible per Day	None
Hospital Services	No copay per admission
Physicians and Surgeons' Services	Included in admission
Emergency Services	
Emergency Room Treatment	$90 waived if admitted
Non-emergency or non-urgent use of ER	$90 per visit if approved
Ambulance	$25 per trip
Urgent Care Facility Services	$20 copay per visit
Physician Office Visit	$20 Copay per visits
After Hours	$20 copay per visit
Maternity Care	
Physician Office Visit	No charge
Maternity Care - Inpatient Delivery	No charge
Midwife delivery services	Include in hospital

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Plan Changes are in Orange	**2024 In-Network**
Mental Health	
Deductible per Confinement	None
Deductible per Day	None
Mental Health Inpatient	No copay per admission
Mental Health-Inpatient Plan Maximums	190-day lifetime limit in a psychiatric hospital
Mental Health Outpatient	$20/35 per visit
Mental Health - Group Therapy	$10 Copay
Mental Health-Outpatient Plan Maximums	None
Severe Mental Illness	No charge for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit; 190 lifetime days psychiatric hospital
Substance Abuse	
Deductible per Confinement	None
Deductible per Day	None
Detoxification	No charge
Substance Abuse - Inpatient Treatment	No charge per inpatient admission with prior authorization if medically necessary and in compliance
Substance Abuse-Inpatient Plan Maximums	None
Substance Abuse-Outpatient	**$20 copay Individual visit / $10 copay per group visit**
Substance Abuse-Outpatient Plan Maximums	None
Rehabilitation Therapy	
Inpatient Rehabilitation	No charge
Outpatient Physical, Occupational, and Speech Therapy	$20 Copay
Alternative Care	
Chiropractic Care	$20 Copay up to 20 visits per period
Acupuncture	$15 Copay for 20 visits for Chronic Lower Back Pain
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 by health education classes 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	Office copay and outpatient surgery cost sharing
Home Health Care	Covered at no charge
Skilled Nursing Facility Care	Covered up to 100 days per benefit period at no charge
Hospice Care	No charge covered per Medicare guidelines. Covered under original Medicare
Hearing Aids	Not Covered

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Plan Changes are in Orange	**2024 In-Network**
Family Planning	
Tubal ligation	$100 copay
Vasectomy	$100 copay
Contraceptive Drugs	**$10 copay generic**
Contraceptive Devices	100% covered
Infertility Testing	**$20 copay**
Infertility Treatments - Office Visit	**$20 copay**
Infertility Treatments - Surgery	**$100 copay outpatient / No Charge inpatient**
In Vitro Fertilization	**Not covered**
Infertility Treatments - Lifetime Maximum	**None**
Vision Care	
Eye Examination	$20 copay or $35 for specialist
Lenses	Not covered
Frames	Not covered
Contact lenses- necessary	Covered following surgery for Cataracts at no charge.
Contact lenses-elective	Not covered
Lasik Eye Surgery	Not covered
Organ and Tissue Transplants	
Organ Transplant -Inpatient	Covered at no charge
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	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant
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	Not Applicable
Prescription Drug Coverage	
Annual Prescription Deductible - Family	None
Annual Prescription Deductible - Individual	None
Out-of-Pocket Maximums - Individual	None
Out-of-Pocket Maximums - Family	None
Annual Maximum Benefit	None
Lifetime Maximum Benefit	None
Generic Substitution	Substitute as determined by provider
Retail Refill Penalty	N/A
Prescription Drug Retail	
Retail - Generic	$10 for 30 day supply
Retail - Brand Formulary	$30 for 30 day supply
Retail - Brand Non-Formulary	$30 for 30-day supply when approved
Single Source Brand	$30 for 30 day supply
Multi Source Brand	$30 for 30 day supply
Injectable Medications	$30 copay
Prescription Drug Mail Order	
Mail-Order - Generic	$20 for up to 90-day supply
Mail-Order - Brand Formulary	$60 for up to 90-day supply
Mail-Order - Brand Non-Formulary	$60 for up to 90-day supply when approved
Single Source Brand	$30 for 30-day retail or $60 for 90-day supply
Multi Source Brand	$60 for 90-day supply
Injectable Medications	$30 per injection
Day Supply	30 day retail, 90 day mail order
Other Services - Prescription Drugs	
Over the Counter	Not covered
Prenatal Vitamins	Not Covered
Diabetic Supplies	No charge for supplies to monitor blood glucose.
Lifestyle Drugs	Not Covered
Contraceptives - Injectable	$20 office visit copay
Fertility Drugs	not covered
Smoking Cessation	No charge for Medicare-covered smoking and tobacco use cessation preventive benefits
Cosmetic Medications	Not covered
Nutritional Supplements	Not covered