Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2023 In-Network**	**Comments**
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	100% after applicable copay	20% for some Rx 20%/50% out of area
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	Diagnostic No charge/ $35 per encounter $20 office visit copay may apply. 50% coinsurance Infertility (2022)	
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	

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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	
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; up to 60 days per condition per accumulation period	
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	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	**2023 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	**Infertility benefits may change in 2023 in Colorado per recent passing of Bill**	
Infertility Treatments - Office Visit	**Infertility benefits may change in 2023 in Colorado per recent passing of Bill**	
Infertility Treatments - Surgery	**Infertility benefits may change in 2023 in Colorado per recent passing of Bill**	
In Vitro Fertilization	**Infertility benefits may change in 2023 in Colorado per recent passing of Bill**	
Infertility Treatments - Lifetime Maximum	**Infertility benefits may change in 2023 in Colorado per recent passing of Bill**	
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	
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	

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Prescription Drug Mail Order		
Mail-Order - Generic	$20 Generic up to 90 days	Specialty RX 20% Coinsurance up to a maximum of $25
Mail-Order - Brand Formulary	$60 Brand up to 90 days	Specialty RX 20% Coinsurance up to a maximum of $25
Mail-Order - Brand Non-Formulary	Through special exception process	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 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	**Not covered 2022; benefit may change 2023**	
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	