Active Employees and Pre-65 Retirees (Non-Medicare Only)	Kaiser Permanente HMO - Colorado	
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Plan Changes are in Orange	**2027 In-Network**	**Comments**
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	90%	
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	$125	
Family Annual Deductible	$250	
Applies to Out-of-Pocket Maximum	Yes	
Prescription benefits are covered under medical deductible	Yes	
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	
Outpatient Services		
Primary Care Physician Visits	$20 per visit	
Specialist Visit	$35 per visit	
Lab tests and X-ray	X-ray: 90%; Lab: 90%	
Specialized Imaging	$100 per encounter (Plan Deductible does not apply)	
Outpatient Surgery	90%	
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	90%	
Physicians and Surgeons' Services	90%	
Emergency Services		
Emergency Room Treatment	$75 per visit; waived if admitted	
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	90%	
Maternity Care - Inpatient Delivery	90%	
Midwife delivery services	90%; at facilities where available	**Coverage for doula services now applies.**

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Mental Health		
Deductible per Confinement	None	
Deductible per Day	None	
Mental Health Inpatient	90%	
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	90% for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit	
Substance Abuse		
Deductible per Confinement	None	
Deductible per Day	None	
Detoxification	90%	
Substance Abuse - Inpatient Treatment	90% 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	90%; 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	90% when medically necessary and authorized by a Plan physician for inpatient care	
Durable Medical Equipment	90% when prescribed by a Plan physician in accordance with Formulary guidelines	
Prosthetic and Orthotic Appliances	90% when prescribed by a Plan physician in accordance with Formulary guidelines	
Smoking Cessation	90% 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	90% when prescribed by a Plan physician (Unlimited Visits)	
Skilled Nursing Facility Care	90%, up to 100 days per benefit period	
Hospice Care	90% when authorized by a Plan physician for a terminal diagnosis with life expectancy of 6 months or less	
Hearing Aids	Pediatric 90% Coinsurance / 1 device per ear / every 60 months. 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	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	

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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 $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	