

**The Exclusive Provider Organization (EPO) Plan from Kaiser Permanente
University of Colorado Health and Welfare Plan employee benefit summary**

The services described below are covered only if all of the terms and conditions in the *Benefits Booklet* are satisfied.

| PLAN FEATURES | |
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| Annual out-of-pocket maximum for certain services Per person/Per family | \$4,000 / \$10,000 |
| Annual deductible | None |
| Lifetime maximum | None |
| Professional services | YOU PAY |
| Routine preventive physical exams | \$0 |
| Primary care (includes urgent care) | \$30 |
| Specialty care | \$40 |
| Well-child preventive care visits (0–24 months) | \$0 |
| Family planning visits | \$30 Primary \$40 Specialty |
| Scheduled prenatal care visits and first postpartum visit (one-time copay) | \$30 Primary \$40 Specialty |
| Routine vision exams (refractive) | \$30 Optometrist \$40 Ophthalmologist |
| Routine hearing tests | \$30 |
| Physical, occupational, and speech therapy visits (up to 20 visits per therapy per Plan year) | \$30 |
| Outpatient services | |
| Outpatient surgery and certain other outpatient procedures | \$250 per visit |
| Allergy injection visits | \$10 |
| Allergy testing visits | \$40 |
| Non-routine vaccines (immunizations) | \$30 Primary \$40 Specialty |
| X-rays and lab tests | \$0 |
| Hospitalization services | |
| Room and board, surgery, anesthesia, X-rays, lab tests, and drugs | \$250 per day / \$1,000 per admission maximum |
| Emergency health coverage | |
| Emergency Department visits (copay waived if admitted) | \$150 |
| Ambulance services | |
| Ambulance services (per trip) | \$0 |
| Infertility services | |
| Infertility office visits and infertility treatments | 50% |
| Infertility diagnostic lab tests, X-rays, and surgery | 50% |
| Prescription drug coverage (most drugs covered in accord with formulary guidelines) | |
| Participating pharmacies generic (30-day supply) | \$15 |
| Participating pharmacies brand (30-day supply) | \$35 |
| Mail-order generic (90-day supply) | \$30 |
| Mail-order brand (90-day supply) | \$70 |

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| Mental health services | |
| Inpatient psychiatric hospitalization, per admission | \$250 per day / \$1,000 per admission maximum |
| Outpatient individual visits | \$30 |
| Outpatient group visits | \$15 |
| Chemical dependency services | |
| Inpatient detoxification, per admission | \$250 per day / \$1,000 per admission maximum |
| Outpatient individual visits | \$30 |
| Outpatient group visits | \$15 |
| Home health services | |
| Home health care | \$0 up to Unlimited visits per year |
| Other | |
| Skilled nursing facility care | \$0 up to 15 visits per year |
| Hospice care | \$0 up to 100 days per year |

This chart is a summary. It does not explain maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete description of your Plan, please refer to the *Benefits Booklet*.

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente provides only administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

