2011 Kaiser Foundation Health Plan of Colorado
Plan POS, YMCA of Metropolitan Denver, Group #01117
Denver Boulder— Large Group

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of Service (i.e., an HMO plan with some out-of-network benefits)
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties as determined by zip code.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]	Not Applicable	Calendar year	Calendar year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual**[2b] **b) Family**[2c]	a) No Deductibles b) No Deductibles	a) $500/Individual per calendar year b) $1,500/Family per calendar year	a) $600/Individual per calendar year b) $1,800/Family per calendar year
	If your group has a Pharmacy Deductible, please see Box 11 for information regarding the Pharmacy Deductible. (Note: The Pharmacy Deductible is separate from the medical Deductible (Deductible), noted above)		
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,000/Individual per calendar year b) $4,500/Family per calendar year c) Not Applicable	a) $4,000/Individual per calendar year b) $12,000/Family per calendar year c) No	a) $7,000/Individual per calendar year b) $21,000/Family per calendar year c) No
	For Families, the individual family members are responsible for meeting the Family Out-of-Pocket Maximum (“OPM”), only up to the Individual OPM amount.		

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	None	$1,000,000 Combined Maximum Benefit while insured	
7A. COVERED PROVIDERS	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers	Private Healthcare Systems, Inc. (PHCS) See online provider directory for complete list at www.kp.org	All providers licensed or certified to provide covered benefits
7B. With respect to network plans, are all the providers listed in 7A. accessible to me through my primary care physician?	Yes		Not Applicable

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	Does not apply toward OPM a) $25 Copayment each primary care office visit b) $35 Copayment each specialist care office visit 20% Coinsurance for Office Administered Drugs - Applies toward OPM	Not subject to Deductible; Does not apply toward OPM a) $30 Copayment each primary care office visit b) $40 Copayment each specialist care office visit Only Diagnostic Lab and X-ray performed in a physician's office are included in the office visit Copayment. 30% Coinsurance applies after Deductible is met for all other services (including Office Administered Drugs). (**Note:** All other services except Diagnostic Lab and X-ray performed in a physician's office are subject to the Deductible; apply toward the OPM)	Subject to Deductible; Applies toward OPM a) 50% Coinsurance after Deductible is met b) 50% Coinsurance after Deductible is met
		Routine Lab & Diagnostic X-ray orders may be brought to Kaiser Permanente facilities and completed at the IN-NETWORK benefit level	
	Line 13 may apply for procedures performed during an office visit		
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	Does not apply toward OPM a) $25 Copayment each visit b) $25 Copayment each visit The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance shown above	Not subject to Deductible; Does not apply toward OPM a) $30 Copayment each visit b) $30 Copayment each visit Limited adult services available The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance listed above.	Not subject to Deductible; Does not apply toward OPM a) $70 per visit copay b) $70 per visit copay Limited adult services available The Copayment or Coinsurance for certain preventive care services may differ from the Copayment or Coinsurance listed above.

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care**[5]	a) Routine Prenatal Care $25 Copayment each visit - Does not apply toward OPM b) $500 Copayment per admission - Applies toward OPM	a) Routine Prenatal care - Not subject to Deductible; Does not apply toward OPM $30 Copayment each visit b) Subject to Deductible; Applies toward OPM 30% Coinsurance after Deductible is met.	Subject to Deductible; Applies toward OPM a) Routine Prenatal Care 50% Coinsurance after Deductible is met b) 50% Coinsurance after Deductible is met
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	Does not apply toward OPM $15 Generic/$30 Brand per prescription up to a 30-day supply /20% Coinsurance for specialty drugs up to a maximum of $250 per drug dispensed/ Mail-order drugs available for up to a 90-day supply for two Copaymemts - Certain drugs limited to a 30-day supply For drugs on our approved list, please contact your Clinical Pharmacy Call Center at 1-866-244-4119 or toll-free at 1-800-632-9700 or TTY 1-800-521-4874. **Note:** The Pharmacy Deductible, if applicable, does not apply toward the OPM.	Not subject to Deductible; does not apply toward OPM $25 Copayment for generic or $35 Copayment for brand 20% Coinsurance for specialty drugs, including self-injectables (up to a maximum of $250 per drug dispensed) Limited to a 30-day supply through MedImpact pharmacies Mail-order drugs available for up to a 90-day supply for two Copayments 50% Coinsurance at Out-of-Network pharmacies For drugs on the MedImpact Preferred Drug List, or to locate Network pharmacies, please contact MedImpact toll-free at **1-800-788-2949** or visit www.kp.org Prescriptions for medications on the Kaiser Permanente formulary may also be filled at Kaiser Permanente pharmacies for the applicable IN-NETWORK benefit. Preferred drug status for individual drugs may vary between Kaiser Permanente formulary and the MedImpact Preferred Drug List. **Note:** The Pharmacy Deductible, if applicable, is not subject to the Deductible; does not apply toward the OPM.	
12. INPATIENT HOSPITAL	Applies toward OPM $500 Copayment per admission	Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. Precertification required.	Subject to Deductible; applies toward OPM 50% Coinsurance after Deductible is met. Precertification required.

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
13. OUTPATIENT/ AMBULATORY SURGERY	Applies toward OPM $350 Copayment each visit for outpatient surgery performed in any setting other than inpatient	Subject to Deductible; applies toward OPM 30% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met. Precertification required.	Subject to Deductible; applies toward OPM 50% Coinsurance for outpatient surgery performed in any setting other than inpatient, after Deductible is met. Precertification required.
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	Does not apply toward OPM a) Diagnostic Lab and X-ray - No Charge (100% covered) Therapeutic X-ray - $35 Copayment each visit b) MRI/CT/PET (Special Procedures) - $100 Copayment per procedure	a) Diagnostic Lab - Subject to Deductible; Applies toward OPM 30% Coinsurance after Deductible is met X-ray, including Therapeutic - Subject to Deductible; Applies toward OPM 30% Coinsurance after Deductible is met b) MRI/CT/PET - 30% Coinsurance after Deductible is met. Precertification required for MRI/CT/PET. Only Diagnostic Lab and X-ray performed in a physician's office are included in the office visit Copayment and are not subject to the Deductible; do not apply toward OPM	a) Diagnostic Lab - Subject to Deductible; Applies toward OPM 50% Coinsurance after Deductible is met X-ray, including Therapeutic - Subject to Deductible; Applies toward OPM 50% Coinsurance after Deductible is met b) MRI/CT/PET - 50% Coinsurance after Deductible is met. Precertification required for MRI/CT/PET.
		Routine Lab and Diagnostic X-ray orders may be brought to Kaiser Permanente facilities and completed at the IN-NETWORK benefit level	
15. EMERGENCY CARE[7], [8]	Does not apply toward OPM $150 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient Line 14b procedures (Special Procedures) performed while receiving Emergency Services will generate a separate Copayment per procedure in addition to the Emergency Services Copayment. The Copayment(s) for Special Procedures is (are) waived if admitted as an inpatient.	Covered as IN-NETWORK benefit, regardless of location	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
16. AMBULANCE	Coinsurance only applies toward OPM 20% Coinsurance up to a maximum of $500 per trip	Covered as IN-NETWORK benefit, regardless of location	
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	a) Urgent care[7] - Does not apply toward OPM $150 Copayment each visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient b) Non-routine care - Does not apply toward OPM $25 Copayment each visit at a Kaiser Permanente Plan Facility inside the Service Area or a non-Plan Facility outside the Service Area during office hours c) After-hours care - Does not apply toward OPM $50 Copayment each after-hours visit at a Kaiser Permanente designated after-hours Plan Facility inside the Service Area	a) Urgent care[7] - 30% Coinsurance at a participating provider Urgent care facility, after Deductible is met Emergency Room Care covered as IN-NETWORK benefit b) Non-routine care - Not subject to Deductible; does not apply towards OPM $30 Copayment each visit during normal office hours at a PREFERRED PROVIDER medical office 30% Coinsurance for procedures received during the visit, after Deductible is met (**Note**: procedures received during the visit are subject to Deductible; apply toward OPM) c) After-hours care - Subject to Deductible; applies toward OPM 30% Coinsurance each after-hours visit at PREFERRED PROVIDER NETWORK medical office	a) Urgent care[7] - 50% Coinsurance at a participating provider Urgent care facility, after Deductible is met Emergency Room Care covered as IN-NETWORK benefit b) Non-routine care - Subject to the Deductible; applies toward OPM 50% Coinsurance after Deductible is met, at an OUT-OF-NETWORK medical office c) After-hours care - Subject to the Deductible; applies toward OPM 50% Coinsurance after Deductible is met, each after-hours visit at an OUT-OF-NETWORK medical office
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	See Box 19, below		

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) Inpatient – Does not apply toward OPM $500 Copayment per admission b) Outpatient - Coinsurance only applies toward OPM $25 Copayment each visit Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar.	a) Inpatient - Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met. Pre-certification required. b) Outpatient - Not subject to Deductible; does not apply toward OPM $30 Copayment each visit Pre-certification required	a) Inpatient - Subject to Deductible; applies toward OPM 50% Coinsurance after Deductible is met. Precertification required b) Outpatient - Subject to Deductible; applies toward OPM 50% Coinsurance after Deductible is met Pre-certification required
20. ALCOHOL & SUBSTANCE ABUSE	a) Inpatient Medical Detoxification - Applies toward OPM $500 Copayment per admission. Detoxification is limited to removing toxic substance from the body. Inpatient Residential Rehabilitation –Does not apply toward OPM $500 Copayment b) Outpatient Chemical Dependency - Coinsurance only applies toward OPM $25 Copayment each visit Group visits will be charged at half the Copayment of an individual visit, rounded down to the nearest dollar.	a) Inpatient Medical Detoxification – Subject to Deductible; applies toward OPM 30% Coinsurance per admission, after Deductible is met. Detoxification is limited to removing toxic substance from the body Pre-certification required Inpatient Residential Rehabilitation - 30% Coinsurance after Deductible is met. Pre-certification required b) Outpatient Chemical Dependency – Not subject to Deductible; does not apply toward OPM- $30 Copayment each visit 30% Coinsurance for inpatient professional visits, after Deductible is met. (**Note:** Inpatient professional visits are subject to Deductible; apply toward OPM) Pre-certification required	a) Inpatient Medical Detoxification Subject to Deductible; Applies toward OPM 50% Coinsurance after Deductible is met. Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation - 50% Coinsurance after Deductible is met. Pre-certification required. b) Outpatient Chemical Dependency – Subject to Deductible; Applies toward OPM 50% Coinsurance after Deductible is met

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	For conditions subject to significant improvement within two months		
	Inpatient* –Applies toward OPM $500 Copayment per admission Outpatient* – Does not apply toward OPM $25 Copayment each visit for up to 20 visits per year for each type of therapy (i.e. physical, occupational and speech therapy)	Inpatient* – Benefit covered IN-NETWORK only Outpatient* – Subject to Deductible; applies toward OPM 30% Coinsurance after Deductible is met	Inpatient* – Benefit covered IN-NETWORK only Outpatient* – Subject to Deductible; applies toward OPM 50% Coinsurance after Deductible is met
	*Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services as defined by state law.	*Limited to a combined (PREFERRED PROVIDER NETWORK and OUT-OF-NETWORK) maximum of 20 visits per calendar year for conditions subject to improvement within two months. Limited to a combined maximum of 20 visits per therapy per calendar year for both acute and chronic conditions for children with congenital defects and birth abnormalities from age 3 to age 6. This benefit is also available for eligible children under the age of 3 who are not participating in Early Intervention Services as defined by state law.	
	Therapies for the treatment of autism spectrum disorders are not subject to any visit limits and include long term rehabilitation..		
22. DURABLE MEDICAL EQUIPMENT	Does not apply toward OPM 20% Coinsurance / up to $2,000 annual maximum benefit paid by Health Plan per calendar year Prosthetic arms and legs covered at 20% Coinsurance with no annual maximum benefit. See policy for types and circumstances of coverage.	Subject to Deductible; Applies toward OPM Prosthetic replacement of arms or legs covered at 20% Coinsurance, after deductible is met, with no annual maximum.	Subject to Deductible; Applies toward OPM Prosthetic replacement of arms or legs covered at 20% Coinsurance, after deductible is met, with no annual maximum.
		All other DME must be ordered through IN-NETWORK vendors. See IN-NETWORK policy for types and circumstances of coverage.	
23. OXYGEN	Does not apply toward OPM Not Covered	Benefit covered IN-NETWORK only	
24. ORGAN TRANSPLANTS	For inpatient, see Box 12, Inpatient Hospital.. For outpatient, see applicable benefit in this Health Benefit Plan Description Form Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver.	Benefit covered IN-NETWORK only	

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PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
25. HOME HEALTH CARE	Does not apply toward OPM No Charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area.	Subject to Deductible; applies toward OPM Combined maximum of 60 home health visits per calendar year 30% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
26. HOSPICE CARE	Inpatient Only Applies toward OPM No Charge (100% covered) for hospice care. Not covered outside the Service Area. Note: Home based Hospice does not apply toward OPM	Subject to Deductible; applies toward OPM Limited to $100 per day per benefit period (3 months) for a combined maximum while insured of 3 benefit periods for hospice care program; precertification required 30% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
27. SKILLED NURSING FACILITY CARE	Does not apply toward OPM No Charge (100% covered) for up to 100 days per calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area.	Benefit covered IN-NETWORK only	
28. DENTAL CARE	Not Covered		
29. VISION CARE	Does not apply toward OPM $25 Copayment per eye wellness and refraction exams performed by an Optometrist Hardware not covered	Benefit covered IN-NETWORK only	
30. CHIROPRACTIC CARE	Does not apply toward OPM Not covered.	Not subject to Deductible; does not apply toward OPM $40 Copayment each visit. Maximum of 20 visits per calendar year. Limited to manual manipulation of the spine only.	Not Covered

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Pre-Hospice Special Services Hospice Program, Travel Clinic-pretravel assessment/prescription, Post-mastectomy breast reconstruction, Hearing aids for minors	See attached addendum for significant cancer screening services	

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED[10]	Not Applicable. Plan does not impose limitation periods for pre-existing conditions.		
33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No		
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not Applicable. Plan does not exclude coverage for pre-existing conditions.		
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.		

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PART D: USING THE PLAN

	IN-NETWORK	PREFERRED PROVIDER NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	No	Yes
39. What is the main customer service number?	Member Services can be reached at **303-338-3800** or toll-free at **1-800-632-9700** or TTY **1-800-521-4874**		
40. Whom do I write/call if I have a complaint or want to file a grievance? [11]	Member Services 2500 South Havana Street Aurora, CO 80014 **303-338-3800** or toll-free at **1-800-632-9700** or TTY **1-800-521-4874**		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms LGEOC-DENCOS (01-11), POS Amend (01-10) and GA-Large-DENCOS (01-11) Large Group	Policy form KPIC-GC-POS-LG-2011-CO Large Group	
43. Does the plan have a binding arbitration clause?	Yes	No	

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Endnotes

[1] "Network" refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand-name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility, that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Colorado Health Plan Benefit Description Form Addendum
Kaiser Permanente Cancer Screening Guidelines
(Charges may apply)

Breast Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Clinical breast exam	Annually	As jointly determined by physician and patient
Mammogram	Available annually for all women beginning at age 40 or earlier based upon patient risk	At least every 2 years, particularly after age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider	For those women who meet the following criteria: Patients with a 10% or greater risk of inherited gene defect

Colon and Rectal Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Fecal occult blood test (FIT)	Annually after age 50	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	On an individual basis	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Every 10 years, more frequently for high risk patients	Every 10 years beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.

Cervical Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Pap test	Annually	Every 2 years, starting at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal PAP smears and not high risk.

Prostate Cancer:

Screening	(Frequency subject to Physician recommendation)	Kaiser Permanente Recommendation
Digital rectal exam	Annually	As jointly determined by physician and patient
Serum prostatic specific antigen (PSA)	Annually	As jointly determined by physician and patient. Not recommended for those over 75.