KAISER PERMANENTE®

2008 Colorado Health Benefit Plan Description Form (Preliminary Version)
Kaiser Permanente Insurance Company
PPO Plan TP24A – JEFFERSON CENTER MENTAL HEALTH, Alternate

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Organization Plan
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 throughout Colorado

PART B: SUMMARY OF BENEFITS

<u>Important Note</u>: 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	OUT-OF-NETWORK
4. Deductible Type[2]	Calendar year	Calendar year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2]**	a) $500 / Individual b) $1,500 / Family Deductibles apply once per year.	a) $1,000 / Individual b) $3,000 / Family Deductibles apply once per calendar year.
	The Individual and Family Deductibles are separate deductibles in each tier. For Families, individual family members are responsible for meeting the Family Deductible, only up to the Individual Deductible amount.	
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $1,500 / Individual b) $3,000 / Family c) No Out-of-Pocket annual maximum (OPM) applies once per year.	a) $2,000 / Individual b) $4,000 / Family c) No Out-of-Pocket annual maximum (OPM) applies once per year.
	Deductibles do not apply to the out-of-pocket maximums.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2,000,000 Lifetime Maximum while insured, combined	
7A. COVERED PROVIDERS	Private Healthcare Systems, Inc. (PHCS) See online provider directory at www.kp.org for a complete list of participating providers.	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
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	Not subject to Annual Deductible; does not apply toward OPM a) $30 Copayment each primary care office visit b) $40 Copayment each specialist care office visit Deductibles waived - Only diagnostic lab and X-ray performed in a physician's office are included in the office visit copay. All other services are subject to	Subject to Deductible; applies toward OPM a) 40% Coinsurance after deductible b) 40% Coinsurance after deductible

	deductible and coinsurance.	
9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**	a) $30 per visit copay, deductible waived b) $30 per visit copay, deductible waived Limited adult services are available.	a) 40% coinsurance, deductible waived b) 40% coinsurance, deductible waived Limited adult services are available.
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care**[5]	a) $30 per visit copay, deductible waived b) 20% coinsurance after deductible	Subject to Deductible; applies toward OPM a) 40% coinsurance, deductible waived b) 40% coinsurance after deductible

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	Not subject to Annual Deductible; does not apply toward OPM $20 copay - for Preferred generic $40 copay - for Preferred brand $60 copay - for Non-Preferred Limited to a 30-day supply - two copays for up to a 90-day supply for mail order 20% for diabetic supplies and 20% for Lupron; refer to Schedule of Coverage and Certificate of Insurance for covered self-injectable drugs No coverage at Out-of-Network pharmacies	
12. INPATIENT HOSPITAL	Subject to Deductible; applies toward OPM 20% coinsurance after deductible - Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible - Pre-certification is required.
13. OUTPATIENT/AMBULATORY SURGERY	Subject to Deductible; applies toward OPM 20% coinsurance after deductible - Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible - Pre-certification is required.
14. DIAGNOSTICS **a) Laboratory & X-ray** **b) MRI, nuclear medicine, and other high-tech services**	Subject to Deductible; applies toward OPM a) 20% coinsurance after deductible b) 20% coinsurance after deductible - Pre-certification is required for MRI, CAT or PET. Only diagnostic lab and X-ray performed in a physician's office are included in the office visit copay. All other services are subject to deductible and coinsurance.	Subject to Deductible; applies toward OPM a) 40% coinsurance after deductible b) 40% coinsurance after deductible - Pre-certification is required for MRI, CAT or PET.
15. EMERGENCY CARE[7, 8]	Subject to Deductible; applies toward OPM 20% coinsurance after deductible	Subject to Deductible; applies toward OPM 40% coinsurance after deductible
16. AMBULANCE	Subject to Deductible; applies toward OPM 20% coinsurance after deductible	Subject to Deductible; applies toward OPM 40% coinsurance after deductible
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Subject to Deductible; applies toward OPM 20% coinsurance after deductible per after hours visit at a participating medical office	Subject to Deductible; applies toward OPM 40% coinsurance after deductible at a non-participating medical office during office hours
18. BIOLOGICALLY BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) Inpatient - 20% coinsurance after deductible - Combined maximum benefit (with Out-of- Network) of 45 days per year; applies toward OPM – b) Outpatient - $40 each visit, deductible waived - Combined maximum benefit (with Out-of- Network) of 20 visits per year; does not apply to OPM	Subject to Deductible; applies toward OPM a) Inpatient - 40% coinsurance after deductible - Combined maximum benefit (with In-Network) of 45 days per year – b) Outpatient - 40% coinsurance after deductible - Combined maximum

		benefit (with In- Network) of 20 visits per year
20. ALCOHOL & SUBSTANCE ABUSE	a) Inpatient Medical Detoxification – 20% coinsurance after deductible. Subject to deductible; applies toward OPM - Combined maximum (with Out-of-Network) of 5 days per episode and a combined maximum benefit of 2 episodes while insured under group policy - Detoxification is limited to removing toxic substances from the body. Applies toward OPM Inpatient Residential Rehabilitation - Not covered b) Outpatient Chemical Dependency – $40 each visit, deductible waived - Combined maximum benefit (with Out-of- Network) of 20 visits per year; does not apply toward OPM	a) Inpatient Medical Detoxification –40% coinsurance after deductible. Subject to deductible; applies toward OPM - Combined maximum (with In-Network) of 5 days per episode and a combined maximum benefit of 2 episodes while insured under group policy - Detoxification is limited to removing toxic substances from the body. Inpatient Residential Rehabilitation - Not covered b) Outpatient Chemical Dependency – 40% coinsurance after deductible - Combined maximum benefit (with In-Network) of 20 visits per year

PART B: SUMMARY OF BENEFITS CONTINUED

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Subject to Deductible; applies toward OPM Inpatient - 20% coinsurance after deductible Combined maximum benefit (with Out-of-Network) of 60 days per admission for conditions subject to improvement within two months - Outpatient - 20% coinsurance after deductible - Combined maximum benefit (with Out-of-Network) of 20 visits per year for conditions subject to improvement within two months - In no case will therapy to treat a covered child's congenital defects and birth abnormalities be limited to a combined maximum of less than 20 visits per year for each of the therapies, up to age five	Subject to Deductible; applies toward OPM Inpatient - 40% coinsurance after deductible Combined maximum benefit (with In-Network) of 60 days per admission for conditions subject to improvement within two months - Outpatient - 40% coinsurance after deductible - Combined maximum benefit (with In-Network) of 20 visits per year for conditions subject to improvement within two months - In no case will therapy to treat a covered child's congenital defects and birth abnormalities be limited to a combined maximum of less than 20 visits per year for each of the therapies, up to age five
22. DURABLE MEDICAL EQUIPMENT	20% coinsurance, deductible waived; does not apply to OPM - Prosthetic arms and legs are covered at 20% copay with no annual maximum. See policy for types and circumstances of coverage.	40% coinsurance - Prosthetic arms and legs are covered at 20% copay with no annual maximum. Does not apply to OPM. See policy for types and circumstances of coverage.
	Limited to a combined maximum benefit of $2000 per year	
23. OXYGEN	Not subject to Annual Deductible; does not apply towards OPM 20% coinsurance after deductible -	Not subject to Annual Deductible; does not apply towards OPM 40% coinsurance after deductible
24. ORGAN TRANSPLANTS	Subject to Deductible; applies toward OPM 20% coinsurance after deductible - Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible - Pre-certification is required.
25. HOME HEALTH CARE	Subject to Deductible; applies toward OPM 20% coinsurance after deductible - Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible - Pre-certification is required.
	Limited to a combined maximum of 60 visits per year	

26. HOSPICE CARE	Subject to Deductible; applies toward OPM 20% coinsurance after deductible - limited to $100 per day per benefit period – Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible - limited to $100 per day per benefit period – Pre-certification is required.
	Limited to a combined maximum while insured of three Benefit Periods	
27. SKILLED NURSING FACILITY CARE	Subject to Deductible; applies toward OPM 20% coinsurance after deductible for prescribed skilled nursing facility services at approved skilled nursing facilities - Pre-certification is required.	Subject to Deductible; applies toward OPM 40% coinsurance after deductible for prescribed skilled nursing facility services at approved skilled nursing facilities - Pre-certification is required.
	Limited to a combined maximum of 100 days per calendar year	
28. DENTAL CARE	None	None
29. VISION CARE	Not subject to Annual Deductible; does not apply towards OPM $30 copay, deductible waived for vision exam Limited to one exam every two years - Hardware not covered	Not subject to Annual Deductible; does not apply towards OPM 40% after deductible - Limited to one exam every two years - Hardware not covered
30. CHIROPRACTIC CARE	Not subject to Annual Deductible; does not apply towards OPM $30 copay, deductible waived - Maximum of 20 visits per year, manual manipulation of the spine only	No benefit
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	See attached amendment for significant cancer screening services.	See attached amendment for significant cancer screening services.

PART C: LIMITATIONS AND EXCLUSIONS

	IN-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?	Not applicable	
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.	

PART D: USING THE PLAN

	IN-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	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	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	Yes

39. What is the main customer service number?	888-625-6426 (toll free)
40. Whom do I write/call if I have a complaint or want to file a grievance? [11]	Kaiser Permanente Insurance Company Customer Service Center 2500 S. Havana St. Denver, CO 80014
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	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.	GP-OOA-PP-2004CO, et al. for large groups

Endnote

[1] "Network" refers to a specified group of physicians, hospitals, 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.

Selected Benefit Descriptions
Colorado Health Benefit Description Form Addendum

Kaiser Permanente Insurance Company (KPIC)

<table>
<tr><th>Benefit</th><th>Benefit Level - THIS CHART REPRESENTS HOW KPIC HAS DECIDED TO COMPLY WITH THE CANCER SCREENING MANDATE</th></tr>
<tr><td>31. SIGNIFICANT ADDITIONAL COVERED SERVICES</td><td>
Kaiser Permanente Insurance Company Coverage for Cancer Screening
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Breast Cancer:

Screening	Coverage	Kaiser Permanente Insurance Company’s Recommendation
Clinical breast exam	Unlimited	KPIC suggests that health decisions concerning cancer screening are best made by the patient and the physician. The information provided under “Coverage” shows those tests that are covered by KPIC as prevention. .
Mammogram	1 baseline between ages 35 – 39 1 every 2 years between ages 40 – 49 1 every year for ages 50 plus	
Genetic testing for inherited susceptibility for breast cancer	None	

Colon and Rectal Cancer:

Screening	Coverage	Kaiser Permanente Insurance Company’s Recommendation
Fecal occult blood test (FOBT)	Ages 40 - 64: one annually	
Colonoscopy or Flexible sigmoidoscopy	Two colorectal visualizations between the ages of 50 - 70	
Barium enema	Unlimited	

Cervical Cancer:

Screening	Coverage	Kaiser Permanente Insurance Company’s Recommendation
Pap test	1 screening per year - More if required	

Prostate Cancer:

Screening	Coverage	Kaiser Permanente Insurance Company’s Recommendation
Digital rectal exam	Ages 40 - 49 one per calendar year	
Serum prostatic specific antigen (PSA)	50 and older - one per calendar year	