

# PLAN HIGHLIGHTS AND RATES

Effective July to December 2009

2009 SMALL BUSINESS RATE AREA 1

- Team up with Kaiser Permanente for the one-source answer to all your health care coverage needs.
- On these pages, you'll find an overview of available plan benefits for small businesses.
- A full listing of all Kaiser Permanente plans and benefits can be found in your 2009 Kaiser Foundation Health Plan *Evidence of Coverage* and your Kaiser Permanente Insurance Company *Certificate of Insurance*.

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<sup>1</sup>Tax references relate to federal income tax only. Consult with your financial or tax adviser for more information.

# KAISER PERMANENTE COPAYMENT PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	MOST POPULAR COPAYMENT PLAN				
	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b>	\$0	\$0	\$0	\$0	\$0
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1</sup></b> Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$3,000
<b>IN THE MEDICAL OFFICE</b>					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/Prenatal care <sup>2</sup>	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits <sup>3</sup>	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$0
Infertility services	Not covered	Not covered	Not covered	50%	50%
Occupational, physical, and speech therapy	\$50	\$30	\$20	\$15	\$5
Most labs and imaging	\$10	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50	\$50
Outpatient surgery	\$250 per procedure	\$200 per procedure	\$150 per procedure	\$100 per procedure	\$5 per procedure
<b>EMERGENCY SERVICES</b>					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
<b>PRESCRIPTIONS<sup>4</sup></b>	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)
Generic	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$5 <sup>5</sup>
Brand-name	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 <sup>5</sup>	\$25 <sup>5</sup>	\$15 <sup>5</sup>
<b>HOSPITAL CARE</b>					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
Skilled nursing facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
<b>MENTAL HEALTH SERVICES<sup>6</sup></b>					
In the medical office (up to 20 visits per calendar year)	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital (up to 30 days per calendar year)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
<b>CHEMICAL DEPENDENCY SERVICES</b>					
In the medical office	\$50 individual	\$30 individual	\$20 individual	\$15 individual	\$5 individual
In the hospital (detoxification only)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
<b>OTHER</b>					
Certain durable medical equipment (DME)	Not covered <sup>7</sup>	Not covered <sup>7</sup>	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered	Not covered	Not covered	\$150 allowance <sup>8</sup>	\$150 allowance <sup>8</sup>
Vision exam	\$50	\$30	\$20	\$15	\$5
Home health care (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0	\$0	\$0
Hospice care	\$0	\$0	\$0	\$0	\$0

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

<sup>2</sup>Scheduled prenatal visits and the first postpartum visit

<sup>3</sup>23 months or younger

<sup>4</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>5</sup>This service is not subject to a deductible.

<sup>6</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

<sup>7</sup>Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

<sup>8</sup>Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

# KAISER PERMANENTE COPAYMENT PLANS RATE AREA 1

EFFECTIVE 7/1/09–12/1/09

Copayment plans feature predictable, lower out-of-pocket costs at the time of service and no deductible for medical expenses. Monthly premiums are higher than other plans.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$50 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$185	\$517	\$508	\$720	<30	\$206	\$575	\$565	\$800	<30	\$226	\$632	\$621	\$880
30-39	\$205	\$556	\$523	\$796	30-39	\$227	\$617	\$581	\$883	30-39	\$250	\$679	\$639	\$972
40-49	\$264	\$607	\$502	\$801	40-49	\$293	\$674	\$557	\$890	40-49	\$323	\$743	\$613	\$980
50-54	\$343	\$713	\$566	\$912	50-54	\$382	\$794	\$630	\$1,015	50-54	\$420	\$873	\$693	\$1,116
55-59	\$434	\$911	\$649	\$1,048	55-59	\$482	\$1,013	\$721	\$1,165	55-59	\$531	\$1,115	\$794	\$1,282
60-64	\$535	\$1,017	\$716	\$1,187	60-64	\$595	\$1,130	\$796	\$1,319	60-64	\$654	\$1,243	\$875	\$1,451
65+	\$607	\$1,312	\$913	\$1,442	65+	\$675	\$1,458	\$1,015	\$1,603	65+	\$742	\$1,604	\$1,116	\$1,763
<b>\$30 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$204	\$569	\$560	\$792	<30	\$226	\$632	\$621	\$879	<30	\$249	\$695	\$684	\$967
30-39	\$225	\$611	\$575	\$875	30-39	\$250	\$679	\$639	\$972	30-39	\$275	\$747	\$703	\$1,069
40-49	\$290	\$667	\$551	\$880	40-49	\$322	\$741	\$612	\$978	40-49	\$355	\$816	\$674	\$1,077
50-54	\$378	\$785	\$623	\$1,003	50-54	\$420	\$873	\$692	\$1,116	50-54	\$462	\$960	\$762	\$1,227
55-59	\$477	\$1,002	\$713	\$1,152	55-59	\$530	\$1,113	\$792	\$1,280	55-59	\$583	\$1,225	\$872	\$1,409
60-64	\$589	\$1,118	\$788	\$1,305	60-64	\$654	\$1,242	\$875	\$1,450	60-64	\$719	\$1,366	\$962	\$1,595
65+	\$667	\$1,442	\$1,003	\$1,585	65+	\$742	\$1,603	\$1,115	\$1,762	65+	\$816	\$1,763	\$1,227	\$1,938
<b>\$20 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$224	\$627	\$616	\$873	<30	\$249	\$696	\$685	\$969	<30	\$274	\$766	\$753	\$1,066
30-39	\$248	\$674	\$634	\$965	30-39	\$276	\$749	\$705	\$1,072	30-39	\$303	\$824	\$775	\$1,179
40-49	\$320	\$736	\$608	\$971	40-49	\$356	\$818	\$676	\$1,080	40-49	\$391	\$900	\$743	\$1,188
50-54	\$416	\$865	\$686	\$1,106	50-54	\$463	\$962	\$763	\$1,230	50-54	\$509	\$1,058	\$839	\$1,352
55-59	\$526	\$1,105	\$786	\$1,271	55-59	\$585	\$1,228	\$874	\$1,412	55-59	\$643	\$1,351	\$961	\$1,554
60-64	\$649	\$1,233	\$868	\$1,439	60-64	\$721	\$1,370	\$964	\$1,599	60-64	\$793	\$1,507	\$1,061	\$1,759
65+	\$736	\$1,591	\$1,107	\$1,749	65+	\$818	\$1,768	\$1,230	\$1,944	65+	\$900	\$1,945	\$1,353	\$2,138
<b>\$15 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$240	\$671	\$659	\$934	<30	\$267	\$745	\$733	\$1,037	<30	\$293	\$819	\$806	\$1,140
30-39	\$265	\$721	\$678	\$1,032	30-39	\$295	\$801	\$754	\$1,146	30-39	\$324	\$881	\$829	\$1,261
40-49	\$342	\$787	\$650	\$1,039	40-49	\$380	\$875	\$722	\$1,155	40-49	\$418	\$962	\$794	\$1,270
50-54	\$445	\$925	\$734	\$1,183	50-54	\$495	\$1,029	\$816	\$1,315	50-54	\$544	\$1,131	\$897	\$1,446
55-59	\$563	\$1,182	\$842	\$1,359	55-59	\$625	\$1,313	\$935	\$1,510	55-59	\$688	\$1,445	\$1,028	\$1,662
60-64	\$694	\$1,318	\$928	\$1,539	60-64	\$771	\$1,465	\$1,031	\$1,710	60-64	\$849	\$1,612	\$1,135	\$1,882
65+	\$787	\$1,701	\$1,183	\$1,870	65+	\$875	\$1,891	\$1,315	\$2,079	65+	\$962	\$2,079	\$1,446	\$2,286
<b>\$5 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$301	\$841	\$827	\$1,171	<30	\$335	\$935	\$920	\$1,301	<30	\$368	\$1,028	\$1,011	\$1,431
30-39	\$333	\$905	\$851	\$1,295	30-39	\$370	\$1,005	\$946	\$1,439	30-39	\$407	\$1,106	\$1,040	\$1,583
40-49	\$430	\$989	\$817	\$1,305	40-49	\$477	\$1,098	\$907	\$1,449	40-49	\$525	\$1,208	\$997	\$1,594
50-54	\$559	\$1,162	\$922	\$1,485	50-54	\$621	\$1,291	\$1,024	\$1,650	50-54	\$683	\$1,420	\$1,127	\$1,815
55-59	\$707	\$1,484	\$1,057	\$1,707	55-59	\$785	\$1,648	\$1,173	\$1,895	55-59	\$864	\$1,814	\$1,291	\$2,086
60-64	\$871	\$1,655	\$1,165	\$1,932	60-64	\$968	\$1,839	\$1,295	\$2,147	60-64	\$1,065	\$2,023	\$1,424	\$2,362
65+	\$988	\$2,135	\$1,485	\$2,347	65+	\$1,098	\$2,373	\$1,651	\$2,609	65+	\$1,208	\$2,610	\$1,816	\$2,869

Employee/Dependent codes    EE only = eligible employee only    EE+C = eligible employee plus child or children  
 EE+S = eligible employee plus spouse    EE+S+C = eligible employee plus spouse and child or children

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

<sup>1</sup>Risk adjustment factor

# KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS

EFFECTIVE 7/1/09–12/1/09

## PLAN HIGHLIGHTS

**MOST POPULAR  
DEDUCTIBLE PLAN**

FEATURES	\$30/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,200 PLAN W/HSA MEMBER PAYS	\$0/\$1,500 PLAN W/HSA MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$2,700/\$5,450 <sup>1</sup>	\$2,700/\$5,450 <sup>1</sup>	\$2,200/\$4,400 <sup>2</sup>	\$1,500/\$3,000 <sup>2</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	N/A	N/A	N/A	N/A
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>3</sup></b> Individual/Family	\$5,250/\$10,500 <sup>1</sup>	\$2,700/\$5,450 <sup>1</sup>	\$2,200/\$4,400 <sup>2</sup>	\$1,500/\$3,000 <sup>2</sup>
<b>IN THE MEDICAL OFFICE</b> Office visits Preventive exams <sup>4</sup> Maternity/Prenatal care <sup>4,5</sup> Well-child preventive care visits <sup>4,6</sup> Vaccines (immunizations) <sup>4</sup> Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 \$10 \$10 \$0 \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)
<b>PRESCRIPTIONS<sup>7</sup></b> Generic Brand-name	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible) 30% per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)
<b>MENTAL HEALTH SERVICES<sup>8</sup></b> In the medical office (up to 20 visits per calendar year)  In the hospital (up to 30 days per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office  In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)
<b>OTHER</b> Certain durable medical equipment (DME) <sup>9</sup> Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>This plan carries an embedded deductible. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

<sup>2</sup>This plan has an aggregate deductible. For family enrollment, there is only one deductible for the whole family. Once it's met, either individually or collectively, the family pays only copayments and coinsurance for the remainder of the calendar year, or until the family out-of-pocket maximum is satisfied.

<sup>3</sup>The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

<sup>4</sup>This service is not subject to a deductible.

<sup>5</sup>Scheduled prenatal visits

<sup>6</sup>23 months or younger

<sup>7</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>8</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

<sup>9</sup>Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

# KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS **RATE AREA 1** EFFECTIVE 7/1/09–12/1/09

These deductible plans feature lower monthly premiums and optional employee-owned savings accounts.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$2,700 PLAN WITH HSA</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$98	\$269	\$222	\$324	<30	\$109	\$299	\$247	\$360	<30	\$120	\$328	\$272	\$395
30-39	\$116	\$310	\$234	\$363	30-39	\$129	\$344	\$260	\$403	30-39	\$142	\$379	\$286	\$444
40-49	\$157	\$320	\$245	\$407	40-49	\$174	\$355	\$272	\$451	40-49	\$192	\$391	\$300	\$497
50-54	\$209	\$434	\$286	\$481	50-54	\$233	\$483	\$319	\$535	50-54	\$256	\$531	\$351	\$588
55-59	\$260	\$541	\$337	\$593	55-59	\$289	\$601	\$375	\$659	55-59	\$318	\$661	\$412	\$725
60-64	\$333	\$666	\$412	\$737	60-64	\$370	\$741	\$457	\$820	60-64	\$407	\$815	\$503	\$902
65+	\$404	\$921	\$479	\$966	65+	\$449	\$1,024	\$533	\$1,074	65+	\$494	\$1,126	\$586	\$1,181
<b>\$0/\$2,700 PLAN WITH HSA</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$111	\$304	\$251	\$366	<30	\$123	\$337	\$279	\$406	<30	\$136	\$372	\$307	\$448
30-39	\$131	\$350	\$264	\$410	30-39	\$146	\$389	\$294	\$455	30-39	\$160	\$428	\$323	\$501
40-49	\$177	\$361	\$277	\$459	40-49	\$197	\$402	\$308	\$511	40-49	\$216	\$441	\$338	\$561
50-54	\$237	\$492	\$324	\$545	50-54	\$263	\$546	\$360	\$604	50-54	\$289	\$600	\$396	\$664
55-59	\$294	\$611	\$381	\$670	55-59	\$326	\$678	\$423	\$743	55-59	\$359	\$746	\$465	\$818
60-64	\$376	\$753	\$465	\$833	60-64	\$418	\$837	\$517	\$926	60-64	\$460	\$921	\$569	\$1,019
65+	\$457	\$1,041	\$542	\$1,092	65+	\$507	\$1,156	\$602	\$1,213	65+	\$558	\$1,272	\$662	\$1,334
<b>\$0/\$2,200 PLAN WITH HSA</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$128	\$350	\$289	\$422	<30	\$142	\$389	\$321	\$469	<30	\$156	\$427	\$353	\$515
30-39	\$151	\$403	\$305	\$472	30-39	\$168	\$448	\$339	\$524	30-39	\$184	\$492	\$372	\$576
40-49	\$204	\$416	\$319	\$529	40-49	\$227	\$463	\$355	\$588	40-49	\$249	\$508	\$390	\$646
50-54	\$272	\$565	\$373	\$626	50-54	\$303	\$629	\$415	\$696	50-54	\$333	\$691	\$456	\$765
55-59	\$338	\$703	\$438	\$771	55-59	\$376	\$782	\$487	\$857	55-59	\$413	\$859	\$536	\$942
60-64	\$433	\$867	\$535	\$959	60-64	\$481	\$963	\$595	\$1,066	60-64	\$530	\$1,060	\$655	\$1,173
65+	\$526	\$1,199	\$624	\$1,258	65+	\$584	\$1,332	\$693	\$1,397	65+	\$642	\$1,464	\$762	\$1,536
<b>\$0/\$1,500 PLAN WITH HSA</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$138	\$377	\$312	\$454	<30	\$153	\$419	\$346	\$505	<30	\$168	\$461	\$381	\$555
30-39	\$163	\$435	\$329	\$509	30-39	\$181	\$483	\$365	\$565	30-39	\$199	\$532	\$402	\$623
40-49	\$220	\$449	\$344	\$570	40-49	\$244	\$498	\$382	\$633	40-49	\$269	\$549	\$421	\$697
50-54	\$294	\$610	\$403	\$675	50-54	\$326	\$677	\$447	\$750	50-54	\$359	\$745	\$492	\$825
55-59	\$365	\$759	\$473	\$832	55-59	\$405	\$842	\$525	\$923	55-59	\$446	\$927	\$578	\$1,016
60-64	\$467	\$935	\$577	\$1,035	60-64	\$519	\$1,039	\$642	\$1,150	60-64	\$571	\$1,143	\$706	\$1,265
65+	\$567	\$1,293	\$673	\$1,356	65+	\$630	\$1,436	\$748	\$1,506	65+	\$693	\$1,580	\$822	\$1,657

**Employee/Dependent codes**    **EE only = eligible employee only**    **EE+S = eligible employee plus spouse**    **EE+C = eligible employee plus child or children**    **EE+S+C = eligible employee plus spouse and child or children**

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

<sup>1</sup>Risk adjustment factor

# KAISER PERMANENTE DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,000 PLAN MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$1,500/\$3,000 <sup>1</sup>	\$1,000/\$2,000 <sup>1</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand prescriptions	\$250 for brand prescriptions
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1,2</sup></b> Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000
<b>IN THE MEDICAL OFFICE</b>		
Office visits <sup>3</sup>	\$30	\$30
Preventive exams <sup>3</sup>	\$30	\$30
Maternity/prenatal care <sup>3,4</sup>	\$0	\$0
Well-child preventive care visits <sup>3,5</sup>	\$0	\$0
Vaccines (immunizations) <sup>3</sup>	\$0	\$0
Allergy injections	\$5 (after deductible)	\$5 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	\$30 (after deductible)	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	\$250 (after deductible)	\$250 (after deductible)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	\$100 (after deductible)	\$100 (after deductible)
Ambulance	\$75 (after deductible)	\$75 (after deductible)
<b>PRESCRIPTIONS<sup>6</sup></b>		
Generic <sup>3</sup>	(up to a 100-day supply) \$10	(up to a 100-day supply) \$10
Brand-name	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
<b>HOSPITAL CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day (after deductible)	\$500 per day (after deductible)
Skilled nursing facility care	\$50 per day (after deductible) (up to 60 days per benefit period)	\$50 per day (after deductible) (up to 60 days per benefit period)
<b>MENTAL HEALTH SERVICES<sup>7</sup></b>		
In the medical office <sup>3</sup> (up to 20 visits per calendar year)	\$30 (for individual therapy) \$15 (for group therapy)	\$30 (for individual therapy) \$15 (for group therapy)
In the hospital (up to 30 days per calendar year)	\$500 per day (after deductible)	\$500 per day (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office <sup>3</sup>	\$30 (for individual therapy)	\$30 (for individual therapy)
In the hospital (detoxification only)	\$500 per day (after deductible)	\$500 per day (after deductible)
<b>OTHER</b>		
Certain durable medical equipment (DME) <sup>8</sup>	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered
Vision exam <sup>3</sup>	\$30	\$30
Home health care <sup>3</sup> (up to 100 two-hour visits per calendar year)	\$0	\$0
Hospice care <sup>3</sup>	\$0	\$0

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>This plan carries an embedded deductible. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

<sup>2</sup>The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

<sup>3</sup>This service is not subject to a deductible.

<sup>4</sup>Scheduled prenatal visits and the first postpartum visit

<sup>5</sup>23 months or younger

<sup>6</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>7</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

<sup>8</sup>Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

# KAISER PERMANENTE DEDUCTIBLE HMO PLANS RATE AREA 1

EFFECTIVE 7/1/09–12/1/09

Deductible plans feature affordable monthly rates and a fixed copayment for services such as office visits and preventive care. Deductibles must be met before members can receive certain services for a copayment or coinsurance.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$1,500 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$133	\$364	\$301	\$439	<30	\$148	\$405	\$335	\$488	<30	\$163	\$446	\$369	\$537
30–39	\$157	\$420	\$317	\$492	30–39	\$175	\$467	\$353	\$547	30–39	\$192	\$513	\$388	\$601
40–49	\$213	\$434	\$333	\$551	40–49	\$236	\$482	\$369	\$612	40–49	\$260	\$530	\$407	\$673
50–54	\$284	\$590	\$389	\$653	50–54	\$316	\$656	\$433	\$726	50–54	\$347	\$720	\$475	\$797
55–59	\$353	\$734	\$458	\$805	55–59	\$392	\$815	\$508	\$893	55–59	\$431	\$896	\$559	\$982
60–64	\$452	\$904	\$559	\$1,000	60–64	\$502	\$1,005	\$621	\$1,112	60–64	\$552	\$1,105	\$682	\$1,223
65+	\$548	\$1,250	\$650	\$1,311	65+	\$609	\$1,388	\$723	\$1,456	65+	\$670	\$1,527	\$795	\$1,602
<b>\$30/\$1,000 PLAN</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$156	\$427	\$353	\$514	<30	\$173	\$474	\$392	\$571	<30	\$191	\$522	\$432	\$629
30–39	\$184	\$492	\$372	\$576	30–39	\$205	\$547	\$413	\$640	30–39	\$225	\$601	\$454	\$704
40–49	\$249	\$508	\$389	\$645	40–49	\$277	\$565	\$433	\$718	40–49	\$304	\$621	\$476	\$789
50–54	\$333	\$691	\$456	\$765	50–54	\$370	\$768	\$507	\$850	50–54	\$407	\$844	\$557	\$934
55–59	\$413	\$859	\$535	\$942	55–59	\$459	\$954	\$595	\$1,046	55–59	\$505	\$1,050	\$655	\$1,151
60–64	\$529	\$1,059	\$654	\$1,172	60–64	\$588	\$1,177	\$727	\$1,302	60–64	\$647	\$1,295	\$800	\$1,433
65+	\$642	\$1,464	\$762	\$1,536	65+	\$713	\$1,626	\$846	\$1,706	65+	\$785	\$1,789	\$932	\$1,877

**Employee/Dependent codes**    EE only = eligible employee only    EE+C = eligible employee plus child or children  
 EE+S = eligible employee plus spouse    EE+S+C = eligible employee plus spouse and child or children

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

<sup>1</sup>Risk adjustment factor

# KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	\$30/\$2,500 PLAN WITH HRA MEMBER PAYS	\$30/\$1,500 PLAN WITH HRA MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>1</sup></b> Individual/Family	\$2,500/\$5,000	\$1,500/\$3,000
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand-name prescriptions	\$250 for brand-name prescriptions
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1,2</sup></b> Individual/Family	\$5,000/\$10,000	\$3,000/\$6,000
<b>IN THE MEDICAL OFFICE</b>		
Office visits	\$30 (after deductible)	\$30 (after deductible)
Preventive exams <sup>3</sup>	\$30	\$30
Maternity/Prenatal care <sup>3,4</sup>	\$10	\$10
Well-child preventive care visits <sup>3,5</sup>	\$10	\$10
Vaccines (immunizations) <sup>3</sup>	\$0	\$0
Allergy injections	\$0 (after deductible)	\$0 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	\$30 (after deductible)	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	20% (after deductible)	20% (after deductible)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	\$150 (after deductible)	\$150 (after deductible)
<b>PRESCRIPTIONS<sup>6</sup></b>		
Generic <sup>3</sup>	(up to a 100-day supply) \$10	(up to a 100-day supply) \$10
Brand-name	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
<b>HOSPITAL CARE</b>		
Physicians' services, room and board, tests, medications, supplies, therapies	20% per admission (after deductible)	20% per admission (after deductible)
Skilled nursing facility care	20% per day (after deductible) (up to 100 days per benefit period)	20% per day (after deductible) (up to 100 days per benefit period)
<b>MENTAL HEALTH SERVICES<sup>7</sup></b>		
In the medical office (up to 20 visits per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)
In the hospital (up to 30 days per calendar year)	20% per admission (after deductible)	20% per admission (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
In the medical office	\$30 (after deductible for individual therapy)	\$30 (after deductible for individual therapy)
In the hospital (detoxification only)	20% per admission (after deductible)	20% per admission (after deductible)
<b>OTHER</b>		
Certain durable medical equipment (DME) <sup>8</sup>	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered
Vision exam <sup>3</sup>	\$30	\$30
Home health care <sup>3</sup> (up to 100 two-hour visits per calendar year)	\$0	\$0
Hospice care <sup>3</sup>	\$0	\$0

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

**Note:** Employer must fund at least 25 percent of the subscriber's deductible for the \$30/\$1,500 Deductible HMO Plan with HRA and at least 40 percent of the subscriber's deductible for the \$30/\$2,500 Deductible HMO Plan with HRA. With an HRA, you are required to work with your own chosen third-party administrator.

<sup>1</sup>This plan carries an embedded deductible. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

<sup>2</sup>The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

<sup>3</sup>This service is not subject to a deductible.

<sup>4</sup>Scheduled prenatal visits and the first postpartum visit

<sup>5</sup>23 months or younger

<sup>6</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>7</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

<sup>8</sup>Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

# KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA RATE AREA 1

EFFECTIVE 7/1/09–12/1/09

An IRS-regulated, employer-sponsored program that allows your employees to receive tax-free dollars from you to pay for covered medical expenses. Administrative fees apply.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$2,500 PLAN WITH HRA<sup>2</sup></b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$127	\$347	\$287	\$418	<30	\$141	\$386	\$319	\$465	<30	\$155	\$424	\$351	\$511
30–39	\$150	\$400	\$303	\$468	30–39	\$166	\$444	\$335	\$520	30–39	\$183	\$489	\$369	\$573
40–49	\$203	\$414	\$317	\$526	40–49	\$225	\$459	\$352	\$583	40–49	\$248	\$506	\$388	\$643
50–54	\$270	\$561	\$370	\$621	50–54	\$301	\$624	\$412	\$691	50–54	\$331	\$687	\$453	\$760
55–59	\$336	\$698	\$436	\$765	55–59	\$373	\$776	\$484	\$851	55–59	\$410	\$853	\$532	\$935
60–64	\$430	\$861	\$532	\$953	60–64	\$478	\$957	\$591	\$1,059	60–64	\$526	\$1,053	\$650	\$1,165
65+	\$522	\$1,190	\$619	\$1,248	65+	\$580	\$1,322	\$688	\$1,387	65+	\$638	\$1,455	\$757	\$1,526
<b>\$30/\$1,500 PLAN WITH HRA<sup>2</sup></b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$142	\$388	\$321	\$468	<30	\$157	\$431	\$356	\$519	<30	\$173	\$474	\$392	\$571
30–39	\$167	\$447	\$337	\$523	30–39	\$186	\$497	\$375	\$582	30–39	\$205	\$547	\$413	\$640
40–49	\$226	\$462	\$354	\$587	40–49	\$251	\$513	\$393	\$652	40–49	\$277	\$565	\$433	\$718
50–54	\$302	\$627	\$414	\$694	50–54	\$336	\$697	\$460	\$772	50–54	\$369	\$767	\$505	\$849
55–59	\$375	\$780	\$486	\$855	55–59	\$417	\$867	\$541	\$950	55–59	\$459	\$954	\$595	\$1,046
60–64	\$481	\$963	\$595	\$1,065	60–64	\$534	\$1,069	\$660	\$1,183	60–64	\$588	\$1,177	\$727	\$1,302
65+	\$583	\$1,330	\$692	\$1,395	65+	\$648	\$1,478	\$769	\$1,550	65+	\$713	\$1,626	\$846	\$1,706

Employee/Dependent codes    EE only = eligible employee only    EE+C = eligible employee plus child or children  
 EE+S = eligible employee plus spouse    EE+S+C = eligible employee plus spouse and child or children

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

<sup>1</sup>Risk adjustment factor

<sup>2</sup>Rates do not include contributions to the HRA plan. Administrative fees apply.

# KAISER PERMANENTE \$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$0		\$500/\$1,000 <sup>1</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$0	\$0	Not covered
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1,2,3</sup></b> Individual/Family	\$3,000/\$6,000	\$3,000/\$9,000	\$6,000/\$18,000
<b>IN THE MEDICAL OFFICE</b>			
Office visits	\$35	\$45	50%
Routine adult physical exams	\$35	\$45	Not covered
Adult preventive screening exam	\$35	\$45	50%
Maternity/Prenatal care <sup>5</sup>	\$0	\$25	50%
Well-child preventive care visits	\$0 <sup>6</sup>	\$25 <sup>7</sup>	50% <sup>7</sup>
Vaccines (immunizations)	\$0	Not covered	Not covered
Allergy injections	\$5	\$25	50%
Infertility services <sup>8</sup>	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$35	\$45 <sup>9</sup>	50% <sup>9</sup>
Most labs and imaging	\$10	30%	50%
MRI/CT/PET	\$50	30%	50%
Outpatient surgery	\$100	30%	50% <sup>4</sup>
<b>EMERGENCY SERVICES</b>			
Emergency Department visits (waived if admitted directly to hospital)	\$100	Emergency Department visits and ambulance for emergency medical conditions are covered as an HMO benefit for services received at any provider.	
Ambulance	\$75		
<b>PRESCRIPTIONS</b> (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies) <sup>10</sup>	Obtained at participating MedImpact pharmacies <sup>11</sup>	Obtained at non-Kaiser Permanente and non-MedImpact pharmacies
Generic	\$10	\$15	Not covered
Brand-name	\$35	\$40	Not covered
Nonformulary	\$50	\$60	Not covered
<b>HOSPITAL CARE</b>			
Physicians' services, room and board, tests, medications, supplies, therapies	\$200 per day	30%	50% <sup>13</sup>
Skilled nursing facility care	\$0 <sup>12</sup>	30% <sup>9</sup>	50% <sup>9,13</sup>
<b>MENTAL HEALTH SERVICES<sup>14</sup></b>			
In the medical office (up to 20 visits per calendar year)	\$35 individual therapy \$17 group therapy	\$45 individual therapy Group therapy not covered	50% individual therapy Group therapy not covered
In the hospital (up to 30 days per calendar year)	\$200 per day	Not covered	Not covered
<b>CHEMICAL DEPENDENCY SERVICES</b>			
In the medical office (counseling for dependency; medical management of withdrawal symptoms)	\$35 individual therapy \$5 group therapy	Individual therapy not covered Group therapy not covered	Individual therapy not covered Group therapy not covered
In the hospital (medical management of withdrawal symptoms)	\$200 per day	Not covered	Not covered
<b>OTHER</b>			
Certain durable medical equipment (DME) <sup>15</sup>	\$0	30% <sup>16</sup>	50% <sup>16</sup>
Prosthetics, orthotics, and special footwear	\$40	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered	Not covered
Vision exam	\$35	Not covered	Not covered
Home health care	\$0 (up to 100 two-hour visits per calendar year)	20% <sup>17</sup>	20% <sup>17</sup>
Hospice care	\$0	30% <sup>18</sup>	50% <sup>18</sup>

**Note:** For your group to be eligible for the \$35 POS Plan, the \$40/\$2,500 PPO Plan with HSA option, or the \$40/\$1,000 PPO Plan, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one HMO plan. When a KPIC POS or PPO plan is offered, at least 70 percent of all enrolled employees must be enrolled in an HMO plan. Combined enrollment in KPIC POS and PPO insurance plans may not exceed 30 percent.

See footnotes and other important information on pages 11 and 16.

# KAISER PERMANENTE \$35 POS PLAN RATE AREA 1

EFFECTIVE 7/1/09–12/1/09

Our point-of-service plan gives employees the flexibility to choose physicians and services inside or outside the Kaiser Permanente network.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>19</sup> .90					6 to 15 enrolling employees RAF <sup>19</sup> 1.00					5 or fewer enrolling employees RAF <sup>19</sup> 1.10				
\$35 POS PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$390	\$1,105	\$1,006	\$1,438	<30	\$434	\$1,229	\$1,118	\$1,599	<30	\$477	\$1,351	\$1,230	\$1,759
30–39	\$448	\$1,228	\$1,049	\$1,613	30–39	\$497	\$1,364	\$1,164	\$1,792	30–39	\$547	\$1,500	\$1,281	\$1,971
40–49	\$585	\$1,301	\$1,025	\$1,674	40–49	\$650	\$1,445	\$1,139	\$1,859	40–49	\$715	\$1,590	\$1,253	\$2,046
50–54	\$771	\$1,607	\$1,202	\$1,957	50–54	\$856	\$1,785	\$1,335	\$2,174	50–54	\$942	\$1,964	\$1,469	\$2,392
55–59	\$965	\$2,027	\$1,390	\$2,309	55–59	\$1,072	\$2,252	\$1,544	\$2,565	55–59	\$1,179	\$2,477	\$1,699	\$2,822
60–64	\$1,214	\$2,352	\$1,565	\$2,663	60–64	\$1,349	\$2,613	\$1,739	\$2,959	60–64	\$1,484	\$2,875	\$1,913	\$3,255
65+	\$1,468	\$3,237	\$1,950	\$3,379	65+	\$1,632	\$3,598	\$2,168	\$3,756	65+	\$1,795	\$3,957	\$2,384	\$4,131

Employee/Dependent codes    EE only = eligible employee only    EE+C = eligible employee plus child or children  
 EE+S = eligible employee plus spouse    EE+S+C = eligible employee plus spouse and child or children

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

### \*Based on maximum allowable charge for covered services

Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; or the negotiated rate; or the actual billed charges. The maximum allowable charge **may be** less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

<sup>1</sup>Deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. Lifetime maximum is \$2 million combined for services provided by PHCS network and nonparticipating providers. This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

<sup>2</sup>The annual out-of-pocket maximum (OOPM) is the limit to the total amount that an individual (self-only) or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage* and the *Certificate of Insurance*).

<sup>3</sup>Covered charges incurred to satisfy the out-of-pocket maximum at the PHCS network level will not be applicable toward satisfaction of the out-of-pocket maximum at the nonparticipating providers level. Likewise, covered charges applied to satisfy the out-of-pocket maximum at the nonparticipating providers level will not be applicable toward satisfaction of the out-of-pocket maximum at the PHCS network level. Covered charges incurred to satisfy the out-of-pocket maximum at the Kaiser Permanente in-network providers level will not be applicable toward satisfaction of the out-of-pocket maximum at the PHCS network or nonparticipating providers level. Covered charges at the PHCS network and nonparticipating providers level will not be applicable toward the satisfaction of the out-of-pocket maximum at the Kaiser Permanente in-network providers level.

<sup>4</sup>Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

<sup>5</sup>Scheduled prenatal visits and the first postpartum visit

<sup>6</sup>Well-child care is covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger.

<sup>7</sup>Well-child care (ages 0 to 18) is exempt from deductibles from PHCS network providers and includes immunizations.

<sup>8</sup>In accordance with California law, health care plans and insurers are required to offer contract holders and policyholders the option to purchase coverage of infertility treatment (excluding in vitro fertilization). For details regarding this optional coverage, including how you may elect this coverage and the amount of additional rates, please contact your broker or the Account Management Team at 1-800-790-4661.

<sup>9</sup>All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.

<sup>10</sup>A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments. Nonformulary prescriptions that are not covered as an HMO benefit are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.

<sup>11</sup>Participating MedImpact pharmacy copayments and deductibles are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the OOPM. Select prescription medications are excluded from coverage. Please consult your participating pharmacy directory for a current list of participating pharmacies.

<sup>12</sup>Care in a skilled nursing facility is limited to 100 days per benefit period.

<sup>13</sup>Kaiser Permanente Insurance Company pays a maximum of \$600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

<sup>14</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage* and the KPIC *Certificate of Insurance*.

<sup>15</sup>Please refer to the *Evidence of Coverage* and the *Certificate of Insurance* for more information; most DME is not covered under the HMO (in-network) tier. DME is limited to a combined maximum of \$2,000 per calendar year for services provided by PHCS network and nonparticipating providers, excluding diabetic testing supplies and equipment.

<sup>16</sup>Durable medical equipment benefit is limited to \$2,000 maximum per calendar year for services from PHCS network and nonparticipating providers combined, excluding diabetic testing supplies and equipment.

<sup>17</sup>Home health care is limited to a maximum of 100 visits per calendar year combined for services provided by PHCS network and nonparticipating providers. Deductible amount is limited to a maximum of \$50 per calendar year.

<sup>18</sup>Hospice care is limited to a 180-day lifetime benefit maximum for services from PHCS network and nonparticipating providers combined.

<sup>19</sup>Risk adjustment factor

### HMO exclusions and limitations

Exclusions and limitations are listed in the *Evidence of Coverage* contained in the *Group Agreement*.

FEATURES	PHCS network (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>1</sup></b> Individual/Family	\$2,500/\$5,000	\$3,500/\$7,000
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>2</sup></b> Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
<b>MAXIMUM BENEFIT WHILE INSURED<sup>3</sup></b>	\$5 million	
<b>HOSPITAL CARE</b> Room, board, and critical care units Imaging, including X-rays and lab tests Transplants Physician, surgeon, and surgical services Nursing care, anesthesia, and inpatient prescribed drugs	30% 30% 30% 30% 30%	50% <sup>4</sup> 50% <sup>4</sup> 50% <sup>4</sup> 50% <sup>4</sup> 50% <sup>4</sup>
<b>OUTPATIENT CARE</b> Physician office visits Routine adult physical exams Adult preventive screening exam <sup>5</sup> Well-child preventive care visits (through age 18) <sup>7</sup> Pediatric visits Outpatient surgery Allergy testing visits Allergy injection visits Gynecological visits Maternity/Scheduled prenatal care and first postpartum visit Imaging, including X-rays Lab tests Eye exams for eyeglass prescriptions Hearing exams Occupational, physical, respiratory, and speech therapy visits <sup>8</sup> Diabetic day care management	\$40 copay \$40 copay <sup>5,6</sup> \$40 copay \$25 copay \$40 copay 30% 30% 30% \$40 copay 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% 50% 50% 50% <sup>20</sup> 50% 50% 50% 50% 50% 50% Not covered Not covered 50%
<b>EMERGENCY SERVICES</b> Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service <sup>9</sup> Nonemergency urgent care	\$100 copay, then 50% (copay waived if admitted) 50% 50% 30%	\$100 copay, then 50% (copay waived if admitted) 50% 50% 50%
<b>PRESCRIPTIONS<sup>10</sup></b> Generic drugs Brand-name drugs Self-administered injectable medications <sup>12</sup> Mail-order generic drugs Mail-order brand-name drugs	<b>MedImpact pharmacy<sup>11</sup></b> \$15 copay (maximum 30-day supply) \$35 copay (maximum 30-day supply) 30% \$30 copay (maximum 100-day supply) \$70 copay (maximum 100-day supply)	<b>Non-MedImpact pharmacy</b> Not covered Not covered Not covered Not covered Not covered
<b>MENTAL HEALTH CARE</b> Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child <sup>13</sup> All other covered mental illness <sup>14</sup> Outpatient visits Severe mental illness and serious emotional disturbances of a child <sup>13</sup> All other covered mental illness <sup>15</sup>	30% 30% \$40 copay 30%	50% <sup>4</sup> 50% 50% 50%
<b>ALCOHOL AND CHEMICAL DEPENDENCY<sup>16</sup></b> Inpatient hospitalization <sup>14</sup> Outpatient visits <sup>15</sup>	30% 30%	50% 50%
<b>ADDITIONAL BENEFITS</b> Care in a skilled nursing facility (60-day combined limit per calendar year) Home health care (100-day combined limit per calendar year) Hospice care (180-day combined lifetime limit) Infertility services <sup>17</sup> Durable medical equipment (DME) <sup>18</sup> Prosthetics, orthotics, and special footwear Diabetic equipment and supplies <sup>19</sup>	30% 20% 30% 30% 30% 30% 30%	50% 20% Not covered 50% 50% 50% 30%

**Note:** For your group to be eligible for the \$35 POS Plan, the \$40/\$2,500 PPO Plan with HSA option, or the \$40/\$1,000 PPO Plan, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one HMO plan. When a KPIC POS or PPO plan is offered, at least 70 percent of all enrolled employees must be enrolled in an HMO plan. Combined enrollment in KPIC POS and PPO insurance plans may not exceed 30 percent.

**See footnotes and other important information on pages 13 and 16.**

This plan offers the flexibility of a PPO along with lower monthly premiums and optional employee-owned savings accounts.

**Monthly rates for groups new to Kaiser Permanente**

<b>16 to 50 enrolling employees</b> <b>RAF<sup>21</sup> .90</b>	<b>6 to 15 enrolling employees</b> <b>RAF<sup>21</sup> 1.00</b>	<b>5 or fewer enrolling employees</b> <b>RAF<sup>21</sup> 1.10</b>
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**\$40/\$2,500 PPO INSURANCE PLAN WITH HSA**

Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$294	\$856	\$636	\$961	<30	\$326	\$950	\$706	\$1,066	<30	\$359	\$1,046	\$777	\$1,174
30–39	\$362	\$1,010	\$704	\$1,113	30–39	\$402	\$1,122	\$782	\$1,236	30–39	\$442	\$1,234	\$860	\$1,360
40–49	\$484	\$1,067	\$742	\$1,233	40–49	\$538	\$1,186	\$824	\$1,370	40–49	\$592	\$1,305	\$907	\$1,508
50–54	\$652	\$1,367	\$854	\$1,459	50–54	\$724	\$1,518	\$948	\$1,620	50–54	\$797	\$1,671	\$1,043	\$1,783
55–59	\$803	\$1,687	\$1,003	\$1,775	55–59	\$892	\$1,874	\$1,114	\$1,972	55–59	\$982	\$2,063	\$1,226	\$2,171
60–64	\$1,046	\$2,092	\$1,245	\$2,178	60–64	\$1,163	\$2,325	\$1,384	\$2,421	60–64	\$1,279	\$2,557	\$1,522	\$2,662
65+	\$1,302	\$3,036	\$1,500	\$3,116	65+	\$1,446	\$3,373	\$1,666	\$3,462	65+	\$1,591	\$3,710	\$1,833	\$3,808

<b>Employee/Dependent codes</b>	<b>EE only = eligible employee only</b> <b>EE+S = eligible employee plus spouse</b>	<b>EE+C = eligible employee plus child or children</b> <b>EE+S+C = eligible employee plus spouse and child or children</b>
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Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

**\*Based on maximum allowable charge for covered services**

Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; or the negotiated rate; or the actual billed charges. The maximum allowable charge **may be** less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

<sup>1</sup>Calendar-year deductible amounts are separate for services provided by PHCS network and nonparticipating providers. Covered charges applied towards the satisfaction of the calendar-year deductible may also be applied towards the satisfaction of the out-of-pocket maximum.

<sup>2</sup>Out-of-pocket maximums are separate for services provided by PHCS network and nonparticipating providers.

<sup>3</sup>Maximum benefit amount while insured is combined for services provided by PHCS network and nonparticipating providers.

<sup>4</sup>Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

<sup>5</sup>This service is not subject to a deductible.

<sup>6</sup>Routine adult physical exams are limited to one exam every 12 months and a benefit maximum of \$400 per covered exam.

<sup>7</sup>Well-child preventive care is exempt from deductibles and includes immunizations.

<sup>8</sup>All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

<sup>9</sup>The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all services.

<sup>10</sup>Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when **patient** requests brand-name drug and a generic version is available.

<sup>11</sup>MedImpact pharmacy copayments are subject to the satisfaction of the calendar-year deductible and out-of-pocket maximum. Drugs prescribed for family planning are subject to the calendar-year deductible. Select prescription drugs are excluded from coverage.

<sup>12</sup>Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.

<sup>13</sup>Severe mental illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

<sup>14</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both PHCS network and nonparticipating providers. Kaiser Permanente Insurance Company pays a maximum of \$175 per day for inpatient hospital care received from nonparticipating providers.

<sup>15</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient visits per calendar year combined for both PHCS network and nonparticipating providers.

<sup>16</sup>In addition to the specified day and visit limit noted above, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by PHCS network and nonparticipating providers.

<sup>17</sup>Benefits payable for treatment of infertility are limited to \$1,000 per lifetime combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

<sup>18</sup>Durable medical equipment benefit is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS network and nonparticipating providers.

<sup>19</sup>Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of \$2,000 per calendar year.

<sup>20</sup>Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

<sup>21</sup>Risk adjustment factor

**Important notice regarding the \$40/\$2,500 PPO Insurance Plan with HSA Option**

This chart is a summary of the benefits for a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts (HSAs) in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, as then constituted or later amended. Enrollment in an HDHP that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Please consult with your employer about other eligibility requirements for establishing an HSA-qualified plan.

**Please note:** If you have other health coverage, including coverage under Medicare, in addition to the coverage under this Group Policy, you may not be eligible to establish or contribute to an HSA unless both coverages qualify as High Deductible Health Plans.

Kaiser Permanente Insurance Company (KPIC) does not provide tax advice. The California Department of Insurance does NOT in any way warrant that this plan meets the federal requirements.

Consult with your financial or tax adviser for tax advice or more information about your eligibility for an HSA.

# KAISER PERMANENTE \$40/\$1,000 PPO INSURANCE PLAN PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	PHCS network (PPO) <sup>1</sup>	Nonparticipating providers (out-of-network) <sup>1</sup>
	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>2</sup></b> Individual/Family	\$1,000/\$2,000	
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>2,3</sup></b> Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
<b>MAXIMUM BENEFIT WHILE INSURED<sup>4</sup></b>	\$5 million	
<b>HOSPITAL CARE</b>		
Room, board, and critical care units	30%	50% <sup>5</sup>
Imaging, including X-rays and lab tests	30%	50% <sup>5</sup>
Transplants	30%	50% <sup>5</sup>
Physician, surgeon, and surgical services	30%	50%
Nursing care, anesthesia, and inpatient prescribed drugs	30%	50% <sup>5</sup>
<b>OUTPATIENT CARE</b>		
Physician office visits	\$40 copay <sup>6,7</sup>	50%
Routine adult physical exams	\$40 copay <sup>6,7,8</sup>	Not covered
Adult preventive screening exam	\$40 copay <sup>6,7</sup>	50% <sup>7</sup>
Well-child preventive care visits (through age 18)	\$25 copay <sup>6,9</sup>	50% <sup>9</sup>
Pediatric visits	\$40 copay <sup>6,7</sup>	50%
Outpatient surgery	30%	50% <sup>23</sup>
Allergy testing visits	30%	50%
Allergy injection visits	30%	50%
Gynecological visits	\$40 copay <sup>6,7</sup>	50%
Maternity/Scheduled prenatal care and first postpartum visit	30%	50%
Imaging, including X-rays	30%	50%
Lab tests	30%	50%
Eye exams for eyeglass prescriptions	Not covered	Not covered
Hearing exams	Not covered	Not covered
Occupational, physical, respiratory, and speech therapy visits <sup>10</sup>	30%	50%
Diabetic day care management	30%	Not covered
<b>EMERGENCY SERVICES</b>		
Emergency Department visits	\$100 copay, then 50% (copay waived if admitted)	\$100 copay, then 50% (copay waived if admitted)
Emergency ambulance service	Covered at the nonparticipating providers level	50%
Medically necessary nonemergency ambulance service <sup>11</sup>	Covered at the nonparticipating providers level	50%
<b>PRESCRIPTIONS<sup>12</sup></b>	<b>MedImpact pharmacy<sup>13</sup></b>	<b>Non-MedImpact pharmacy</b>
Generic drugs	\$15 copay <sup>6</sup> (maximum 30-day supply)	Not covered
Brand-name drugs deductible (pharmacy and mail order)	\$200 deductible <sup>6</sup>	Not covered
Brand-name drugs	\$35 copay <sup>6</sup> (maximum 30-day supply)	Not covered
Self-administered injectable medications <sup>14</sup>	30% <sup>6</sup>	Not covered
Mail-order generic drugs	\$30 copay <sup>6</sup> (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	\$70 copay <sup>6</sup> (maximum 100-day supply)	Not covered
<b>MENTAL HEALTH CARE</b>		
Inpatient hospitalization		
Severe mental illness and serious emotional disturbances of a child <sup>15</sup>	30%	50% <sup>5</sup>
All other covered mental illness <sup>16</sup>	30%	50%
Outpatient visits		
Severe mental illness and serious emotional disturbances of a child <sup>15</sup>	\$40 copay <sup>6,7</sup>	50%
All other covered mental illness <sup>17</sup>	30%	50%
<b>ALCOHOL AND CHEMICAL DEPENDENCY<sup>18</sup></b>		
Inpatient hospitalization <sup>16</sup>	30%	50%
Outpatient visits <sup>17</sup>	\$40 copay <sup>6</sup>	Not covered
<b>ADDITIONAL BENEFITS</b>		
Care in a skilled nursing facility (60-day combined limit per calendar year)	30%	50%
Home health care (100-day combined limit per calendar year) <sup>19</sup>	20%	20%
Hospice care (180-day combined lifetime limit)	30%	50%
Infertility services <sup>20</sup>	30%	50%
Durable medical equipment (DME) <sup>21</sup>	30%	50%
Prosthetics, orthotics, and special footwear	30%	50%
Diabetic equipment and supplies <sup>22</sup>	30%	30%

**Note:** For your group to be eligible for the \$35 POS Plan, the \$40/\$2,500 PPO Plan with HSA option, or the \$40/\$1,000 PPO Plan, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one HMO plan. When a KPIC POS or PPO plan is offered, at least 70 percent of all enrolled employees must be enrolled in an HMO plan. Combined enrollment in KPIC POS and PPO insurance plans may not exceed 30 percent.

# KAISER PERMANENTE \$40/\$1,000 PPO INSURANCE PLAN RATE AREA 1

EFFECTIVE 7/1/09–12/1/09

This plan allows members to choose to receive medical services from a contracted provider network or from any licensed nonparticipating provider.

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>24</sup> .90					6 to 15 enrolling employees RAF <sup>24</sup> 1.00					5 or fewer enrolling employees RAF <sup>24</sup> 1.10				
\$40/\$1,000 PPO INSURANCE PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$317	\$924	\$687	\$1,037	<30	\$353	\$1,028	\$764	\$1,154	<30	\$388	\$1,130	\$840	\$1,268
30–39	\$391	\$1,092	\$761	\$1,203	30–39	\$435	\$1,214	\$846	\$1,337	30–39	\$478	\$1,334	\$930	\$1,470
40–49	\$524	\$1,155	\$803	\$1,334	40–49	\$582	\$1,283	\$892	\$1,482	40–49	\$640	\$1,411	\$980	\$1,630
50–54	\$705	\$1,478	\$923	\$1,577	50–54	\$783	\$1,642	\$1,025	\$1,752	50–54	\$861	\$1,805	\$1,127	\$1,926
55–59	\$868	\$1,824	\$1,084	\$1,919	55–59	\$965	\$2,027	\$1,205	\$2,133	55–59	\$1,061	\$2,229	\$1,325	\$2,345
60–64	\$1,131	\$2,262	\$1,346	\$2,355	60–64	\$1,257	\$2,513	\$1,496	\$2,616	60–64	\$1,382	\$2,764	\$1,645	\$2,878
65+	\$1,407	\$3,282	\$1,621	\$3,369	65+	\$1,564	\$3,647	\$1,801	\$3,744	65+	\$1,720	\$4,011	\$1,981	\$4,117

Employee/Dependent codes	EE only = eligible employee only	EE+C = eligible employee plus child or children
	EE+S = eligible employee plus spouse	EE+S+C = eligible employee plus spouse and child or children

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 but no more than 50 full-time employees worldwide (working at least 30 hours per week). Rates are not applicable to groups currently enrolled with Kaiser Permanente. Final rates are contingent upon actual enrollment and review of applications.

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

<sup>2</sup>Medical calendar-year deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

<sup>3</sup>Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the PHCS network tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS network tier will not accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating providers tier.

<sup>4</sup>Maximum benefit while insured is combined for services provided by PHCS network and nonparticipating providers.

<sup>5</sup>Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

<sup>6</sup>Brand-name drug deductible, copayments, and coinsurance paid for physician office visit or paid for prescriptions filled at participating pharmacies are not subject to, nor do they contribute toward, satisfaction of either the calendar-year deductible or the out-of-pocket maximum.

<sup>7</sup>This service is not subject to a deductible.

<sup>8</sup>Routine adult physical exams are limited to one exam every 12 months and \$400 per calendar year.

<sup>9</sup>Well-child preventive care is exempt from deductibles and includes immunizations.

<sup>10</sup>All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

<sup>11</sup>The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all services.

<sup>12</sup>Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the patient requests a brand-name drug and a generic version is available.

<sup>13</sup>MedImpact pharmacy copayments are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the out-of-pocket maximum. Select prescription drugs are excluded from coverage.

<sup>14</sup>Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.

<sup>15</sup>Severe mental illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

<sup>16</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both PHCS network and nonparticipating providers. Kaiser Permanente Insurance Company pays a maximum of \$175 per day for inpatient hospital care received from nonparticipating providers.

<sup>17</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient visits per calendar year.

<sup>18</sup>In addition to the specified day and visit limits noted, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by PHCS network and nonparticipating providers.

<sup>19</sup>Combined maximum deductible of \$50 per calendar year

<sup>20</sup>Benefits payable for treatment of infertility are limited to \$1,000 per calendar year combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

<sup>21</sup>DME is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS network and nonparticipating providers.

<sup>22</sup>Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of \$2,000 per calendar year.

<sup>23</sup>Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

<sup>24</sup>Risk adjustment factor

# NOTES FOR KAISER PERMANENTE POS AND PPO PLANS

## Precertification of services provided by PHCS network and nonparticipating providers

Precertification is required for all hospital confinements, including preadmission testing; inpatient care at a skilled nursing facility or other licensed, freestanding facilities, such as hospice care, home health care, or care at a rehabilitation facility; and select outpatient procedures. Failure to obtain precertification will result in an additional deductible of \$500 per occurrence for covered charges incurred in connection with these services. This additional deductible will not count toward the satisfaction of any calendar-year deductibles or out-of-pocket maximums.

## PHCS network and nonparticipating providers

Unless specifically covered under the group policy, expenses incurred in connection with the following services are excluded: charges, services, or care that are provided or reimbursed by Kaiser Foundation Health Plan; not medically necessary; in excess of the maximum allowable charge; not available in the United States; for personal comfort. Emergency Department facility fees or charges for nonemergency weekend (Friday through Sunday) hospital admissions. Charges arising from work or that can be covered under workers' compensation or any similar law, or for which the group policyholder or member is required by law to maintain alternative insurance or coverage. Charges for military service-related conditions or where care is provided at government expense. Services or care provided in a member's home, by a family member, or by a resident of the household. Dental care, appliances, or orthodontia, unless due to injury to natural teeth. Cosmetic services; plastic surgery; sex transformation; sexual dysfunction; surrogacy arrangements; biotechnology drugs or diagnostics; nonprescription drugs or medicines; treatment, procedures, or drugs Kaiser Permanente Insurance Company determines to be experimental or investigational. Education, counseling, therapy, or care for learning deficiencies or behavioral problems. Services, care, or treatment of or in connection with obesity or weight management. Services, care, or treatment of or in connection with craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder. Services, care, or treatment of or in connection with musculoskeletal therapy; health education; biofeedback; hypnotherapy; routine adult physical exams; immunizations; medical social services; hearing exams, aids, or therapy; radial keratotomy or similar procedures; reversal of sterilization; or routine foot care. Services or care required by a court of law or for insurance, travel, employment, school, camp, government licensing, or similar purposes. Transplants, including donor costs. Custodial care; care in an intermediate care facility; maintenance therapy for rehabilitation; or living or transportation expenses. Treatment of mental illness; substance abuse. Services or supplies necessary to treat an injury to which a contributing cause was a member's: commission of or attempt to commit a felony; engagement in an illegal occupation; intoxication; or under the influence of a narcotic, unless administered by a physician. Services of a private-duty nurse. Vision care, including routine exams, eye refractions, orthoptics, glasses, contact lenses, or fittings; drugs and medicine for smoking cessation; well-child care and immunizations. Extended well-child care. Services for which no charge is normally made in the absence of insurance.

## Important information

Written information on topics related to coverage offered to employer groups in the small group market is available and can be obtained by contacting your broker or your sales representative.

Topics include:

1. Factors that affect rate setting and rate adjustments
2. Provisions related to renewing coverage
3. Geographic areas covered by the Health Plan

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## NOTES FOR ALL PLANS

**Kaiser Permanente plans do not include a pre-existing condition clause.**

HMO benefits are provided by Kaiser Foundation Health Plan, Inc.

KPIC has contracted with the PHCS network to provide access to hospitals and physicians with a commitment to keeping out-of-pocket costs low through contracted rates.

The HMO in-network portion of the point-of-service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC) underwrites the out-of-network portion (the PHCS network and nonparticipating provider portions) of the POS and PPO plans. KPIC is a subsidiary of KFHP.

**This booklet is a summary only.** The Kaiser Foundation Health Plan *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure is not intended for use as a benefit summary, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.

# KAISER PERMANENTE RATE AREA 1

Below is a listing of all ZIP codes within Rate Area 1.

The following counties are entirely within Rate Area 1:

Alameda, San Francisco, San Mateo, and Santa Clara.

Portions of Contra Costa are also within Rate Area 1.

94002	94188	94720	95148
94005	94199	94801-08	95150-61
94010-11	94301-06	94820	95164
94013-28	94309	94850	95170
94030	94401-04	95002	95172-73
94035	94497	95008-09	95190-94
94037-44	94501-02	95011	95196
94060-66	94536-46	95013-15	
94070	94550-52	95020-21	
94074	94555	95026	
94080	94557	95030-33	
94083	94560	95035-38	
94085-89	94566	95042	
94101-05	94568	95044	
94107-12	94577-80	95046	
94114-34	94586-88	95050-56	
94137	94601-15	95070-71	
94139-47	94617-24	95101	
94151	94649	95103	
94156	94659-62	95106	
94158-64	94666	95108-13	
94172	94701-10	95115-36	
94177	94712	95138-41	

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