PLAN HIGHLIGHTS AND RATES

Effective July to December 2009

2009 SMALL BUSINESS RATE AREA 4

KAISER PERMANENTE®

- 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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[1]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	$50 PLAN MEMBER PAYS	$30 PLAN MEMBER PAYS (MOST POPULAR COPAYMENT PLAN)	$20 PLAN MEMBER PAYS	$15 PLAN MEMBER PAYS	$5 PLAN MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE	$0	$0	$0	$0	$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	$250 for brand prescriptions	$250 for brand prescriptions	$0	$0	$0
ANNUAL OUT-OF-POCKET MAXIMUM[1]					
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
IN THE MEDICAL OFFICE					
Office visits	$50	$30	$20	$15	$5
Preventive exams	$50	$30	$20	$15	$5
Maternity/Prenatal care[2]	$15	$0	$0	$0	$0
Well-child preventive care visits[3]	$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
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	$150	$100	$100	$100	$100
Ambulance	$300	$75	$75	$75	$75
PRESCRIPTIONS[4]	(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[5]	$10[5]	$10[5]	$10[5]	$5[5]
Brand-name	$35 (after pharmacy deductible)	$35 (after pharmacy deductible)	$30[5]	$25[5]	$15[5]
HOSPITAL CARE					
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
MENTAL HEALTH SERVICES[6]					
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
CHEMICAL DEPENDENCY SERVICES					
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
OTHER					
Certain durable medical equipment (DME)	Not covered[7]	Not covered[7]	20% ($2,000 maximum)	20% ($2,000 maximum)	20% ($2,000 maximum)
Optical (eyewear)	Not covered	Not covered	Not covered	$150 allowance[8]	$150 allowance[8]
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.

[1]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*).

[2]Scheduled prenatal visits and the first postpartum visit

[3]23 months or younger

[4]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.

[5]This service is not subject to a deductible.

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

[7]Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

[8]Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

KAISER PERMANENTE
COPAYMENT PLANS RATE AREA 4

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

$50 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$182	$509	$501	$709
30–39	$202	$548	$516	$784
40–49	$260	$598	$494	$789
50–54	$338	$703	$558	$899
55–59	$428	$898	$640	$1,033
60–64	$527	$1,001	$705	$1,169
65+	$598	$1,292	$899	$1,420

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$203	$566	$557	$788
30–39	$224	$608	$572	$870
40–49	$289	$665	$549	$877
50–54	$376	$782	$620	$999
55–59	$475	$998	$710	$1,148
60–64	$586	$1,113	$784	$1,299
65+	$665	$1,437	$1,000	$1,580

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$223	$623	$612	$867
30–39	$246	$669	$629	$958
40–49	$318	$731	$604	$965
50–54	$414	$860	$682	$1,099
55–59	$523	$1,098	$782	$1,263
60–64	$645	$1,225	$862	$1,430
65+	$731	$1,580	$1,099	$1,737

$30 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$199	$557	$547	$775
30–39	$220	$598	$563	$856
40–49	$284	$654	$540	$863
50–54	$370	$769	$610	$983
55–59	$468	$982	$699	$1,129
60–64	$577	$1,096	$772	$1,279
65+	$654	$1,413	$983	$1,553

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$222	$619	$609	$861
30–39	$245	$665	$626	$952
40–49	$316	$727	$600	$959
50–54	$411	$854	$678	$1,092
55–59	$520	$1,091	$777	$1,255
60–64	$641	$1,217	$857	$1,421
65+	$727	$1,571	$1,093	$1,727

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$244	$681	$670	$948
30–39	$269	$731	$688	$1,047
40–49	$347	$799	$660	$1,055
50–54	$452	$940	$746	$1,202
55–59	$572	$1,201	$855	$1,381
60–64	$705	$1,339	$943	$1,563
65+	$799	$1,727	$1,201	$1,899

$20 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$218	$609	$599	$847
30–39	$241	$654	$616	$936
40–49	$311	$715	$591	$944
50–54	$404	$840	$666	$1,074
55–59	$511	$1,073	$764	$1,234
60–64	$630	$1,197	$843	$1,397
65+	$715	$1,545	$1,075	$1,698

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$242	$676	$665	$941
30–39	$268	$727	$684	$1,041
40–49	$345	$794	$656	$1,048
50–54	$449	$934	$741	$1,194
55–59	$568	$1,192	$849	$1,371
60–64	$700	$1,330	$936	$1,553
65+	$794	$1,716	$1,194	$1,886

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$266	$744	$731	$1,035
30–39	$294	$799	$752	$1,144
40–49	$380	$874	$722	$1,153
50–54	$494	$1,027	$815	$1,313
55–59	$624	$1,311	$933	$1,508
60–64	$770	$1,463	$1,030	$1,708
65+	$873	$1,887	$1,313	$2,074

$15 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$240	$670	$658	$932
30–39	$265	$719	$677	$1,029
40–49	$341	$785	$648	$1,036
50–54	$444	$923	$733	$1,180
55–59	$562	$1,180	$840	$1,357
60–64	$693	$1,316	$927	$1,536
65+	$786	$1,698	$1,181	$1,867

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$266	$743	$731	$1,034
30–39	$294	$799	$752	$1,144
40–49	$379	$873	$720	$1,152
50–54	$494	$1,027	$815	$1,313
55–59	$624	$1,310	$933	$1,507
60–64	$770	$1,462	$1,030	$1,707
65+	$873	$1,887	$1,312	$2,074

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$293	$818	$804	$1,138
30–39	$324	$879	$827	$1,258
40–49	$417	$960	$793	$1,267
50–54	$543	$1,129	$896	$1,443
55–59	$687	$1,442	$1,027	$1,658
60–64	$847	$1,609	$1,133	$1,878
65+	$960	$2,075	$1,443	$2,281

$5 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$297	$830	$817	$1,155
30–39	$329	$893	$840	$1,278
40–49	$424	$976	$806	$1,288
50–54	$552	$1,147	$910	$1,466
55–59	$697	$1,464	$1,042	$1,684
60–64	$860	$1,634	$1,150	$1,907
65+	$976	$2,109	$1,467	$2,318

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$331	$924	$908	$1,286
30–39	$365	$992	$933	$1,420
40–49	$471	$1,084	$895	$1,431
50–54	$613	$1,274	$1,011	$1,629
55–59	$775	$1,627	$1,158	$1,871
60–64	$956	$1,816	$1,278	$2,120
65+	$1,084	$2,343	$1,630	$2,576

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$364	$1,016	$999	$1,414
30–39	$402	$1,092	$1,027	$1,563
40–49	$518	$1,192	$984	$1,573
50–54	$675	$1,403	$1,113	$1,793
55–59	$852	$1,790	$1,274	$2,059
60–64	$1,051	$1,997	$1,406	$2,331
65+	$1,192	$2,576	$1,792	$2,832

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.

[1]Risk adjustment factor

KAISER PERMANENTE
HSA-QUALIFIED DEDUCTIBLE HMO PLANS
PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

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

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

[1]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.

[2]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.

[3]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*).

[4]This service is not subject to a deductible.

[5]Scheduled prenatal visits

[6]23 months or younger

[7]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.

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

[9]Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

KAISER PERMANENTE

HSA-QUALIFIED DEDUCTIBLE HMO PLANS RATE AREA 4

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

$30/$2,700 PLAN WITH HSA

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$98	$268	$221	$323
30–39	$115	$308	$232	$361
40–49	$156	$318	$244	$404
50–54	$208	$432	$285	$478
55–59	$259	$538	$336	$590
60–64	$331	$663	$409	$734
65+	$402	$917	$477	$962

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$108	$297	$245	$358
30–39	$128	$342	$259	$400
40–49	$173	$353	$271	$449
50–54	$231	$480	$317	$531
55–59	$287	$597	$372	$654
60–64	$368	$737	$455	$815
65+	$447	$1,019	$530	$1,069

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$119	$326	$270	$393
30–39	$141	$377	$285	$441
40–49	$191	$389	$299	$494
50–54	$255	$529	$349	$586
55–59	$316	$657	$410	$720
60–64	$405	$811	$501	$897
65+	$491	$1,120	$583	$1,175

$0/$2,700 PLAN WITH HSA

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$110	$302	$249	$364
30–39	$130	$348	$263	$407
40–49	$176	$359	$275	$456
50–54	$235	$488	$322	$540
55–59	$292	$607	$379	$665
60–64	$375	$750	$463	$830
65+	$454	$1,036	$539	$1,087

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$123	$336	$278	$405
30–39	$145	$387	$293	$453
40–49	$196	$400	$306	$508
50–54	$262	$543	$359	$601
55–59	$325	$676	$421	$741
60–64	$416	$833	$514	$922
65+	$505	$1,151	$599	$1,207

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$135	$369	$305	$445
30–39	$159	$425	$321	$498
40–49	$215	$439	$337	$558
50–54	$288	$598	$394	$662
55–59	$357	$743	$463	$814
60–64	$458	$916	$566	$1,014
65+	$555	$1,266	$659	$1,328

$0/$2,200 PLAN WITH HSA

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$133	$364	$301	$438
30–39	$157	$419	$317	$490
40–49	$212	$433	$332	$550
50–54	$283	$588	$388	$651
55–59	$351	$730	$455	$800
60–64	$450	$901	$556	$997
65+	$546	$1,245	$648	$1,306

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$147	$403	$333	$486
30–39	$174	$465	$351	$544
40–49	$235	$480	$368	$610
50–54	$314	$652	$430	$722
55–59	$390	$811	$506	$889
60–64	$500	$1,001	$618	$1,108
65+	$607	$1,384	$720	$1,452

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$162	$444	$367	$535
30–39	$192	$512	$387	$599
40–49	$259	$529	$405	$672
50–54	$346	$718	$474	$795
55–59	$429	$893	$556	$979
60–64	$550	$1,101	$680	$1,218
65+	$668	$1,523	$793	$1,598

$0/$1,500 PLAN WITH HSA

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$143	$392	$324	$472
30–39	$169	$452	$341	$529
40–49	$229	$467	$358	$593
50–54	$305	$634	$418	$702
55–59	$379	$788	$491	$864
60–64	$486	$972	$601	$1,076
65+	$589	$1,343	$699	$1,409

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$159	$435	$360	$524
30–39	$188	$502	$379	$588
40–49	$254	$518	$397	$658
50–54	$339	$704	$464	$779
55–59	$421	$876	$546	$960
60–64	$540	$1,080	$667	$1,195
65+	$655	$1,493	$777	$1,566

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$175	$479	$396	$577
30–39	$207	$553	$417	$647
40–49	$279	$570	$437	$724
50–54	$373	$775	$511	$858
55–59	$463	$963	$600	$1,056
60–64	$594	$1,188	$734	$1,315
65+	$720	$1,642	$855	$1,723

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.

[1]Risk adjustment factor

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
MEDICAL CALENDAR-YEAR DEDUCTIBLE		
Individual/Family	$1,500/$3,000[1]	$1,000/$2,000[1]
PHARMACY CALENDAR-YEAR DEDUCTIBLE	$250 for brand prescriptions	$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]		
Individual/Family	$3,500/$7,000	$3,500/$7,000
IN THE MEDICAL OFFICE		
Office visits[3]	$30	$30
Preventive exams[3]	$30	$30
Maternity/prenatal care[3,4]	$0	$0
Well-child preventive care visits[3,5]	$0	$0
Vaccines (immunizations)[3]	$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)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)	$100 (after deductible)
Ambulance	$75 (after deductible)	$75 (after deductible)
PRESCRIPTIONS[6]	(up to a 100-day supply)	(up to a 100-day supply)
Generic[3]	$10	$10
Brand-name	$35 (after $250 pharmacy deductible)	$35 (after $250 pharmacy deductible)
HOSPITAL CARE		
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)
MENTAL HEALTH SERVICES[7]		
In the medical office[3] (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)
CHEMICAL DEPENDENCY SERVICES		
In the medical office[3]	$30 (for individual therapy)	$30 (for individual therapy)
In the hospital (detoxification only)	$500 per day (after deductible)	$500 per day (after deductible)
OTHER		
Certain durable medical equipment (DME)[8]	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered
Vision exam[3]	$30	$30
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0
Hospice care[3]	$0	$0

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

[1]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.

[2]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*).

[3]This service is not subject to a deductible.

[4]Scheduled prenatal visits and the first postpartum visit

[5]23 months or younger

[6]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.

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

[8]Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

KAISER PERMANENTE

DEDUCTIBLE HMO PLANS RATE AREA 4

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

$30/$1,500 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$135	$369	$305	$445
30–39	$159	$425	$321	$498
40–49	$215	$439	$336	$558
50–54	$287	$596	$393	$660
55–59	$357	$742	$463	$813
60–64	$457	$915	$565	$1,012
65+	$555	$1,265	$659	$1,327

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$150	$410	$339	$494
30–39	$177	$473	$357	$554
40–49	$239	$488	$374	$620
50–54	$319	$663	$437	$734
55–59	$396	$824	$514	$903
60–64	$508	$1,017	$628	$1,125
65+	$616	$1,405	$731	$1,474

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$165	$451	$373	$543
30–39	$194	$519	$392	$608
40–49	$263	$537	$411	$682
50–54	$351	$729	$481	$807
55–59	$436	$907	$565	$994
60–64	$559	$1,119	$691	$1,238
65+	$678	$1,546	$805	$1,622

$30/$1,000 PLAN

16 to 50 enrolling employees — RAF[1] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$155	$425	$351	$512
30–39	$183	$490	$370	$574
40–49	$248	$506	$388	$643
50–54	$331	$687	$453	$761
55–59	$411	$855	$533	$937
60–64	$527	$1,055	$651	$1,167
65+	$639	$1,457	$758	$1,528

6 to 15 enrolling employees — RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$173	$473	$391	$570
30–39	$204	$545	$412	$638
40–49	$276	$563	$431	$715
50–54	$368	$764	$504	$846
55–59	$457	$950	$592	$1,041
60–64	$586	$1,172	$724	$1,297
65+	$710	$1,619	$843	$1,698

5 or fewer enrolling employees — RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$190	$520	$430	$627
30–39	$224	$599	$452	$701
40–49	$303	$619	$474	$786
50–54	$405	$841	$555	$931
55–59	$503	$1,046	$652	$1,147
60–64	$644	$1,289	$796	$1,426
65+	$781	$1,781	$927	$1,868

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.

[1] Risk adjustment factor

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
MEDICAL CALENDAR-YEAR DEDUCTIBLE[1]		
Individual/Family	$2,500/$5,000	$1,500/$3,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	$250 for brand-name prescriptions	$250 for brand-name prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]		
Individual/Family	$5,000/$10,000	$3,000/$6,000
IN THE MEDICAL OFFICE		
Office visits	$30 (after deductible)	$30 (after deductible)
Preventive exams[3]	$30	$30
Maternity/Prenatal care[3,4]	$10	$10
Well-child preventive care visits[3,5]	$10	$10
Vaccines (immunizations)[3]	$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)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	$150 (after deductible)	$150 (after deductible)
PRESCRIPTIONS[6]	(up to a 100-day supply)	(up to a 100-day supply)
Generic[3]	$10	$10
Brand-name	$35 (after $250 pharmacy deductible)	$35 (after $250 pharmacy deductible)
HOSPITAL CARE		
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)
MENTAL HEALTH SERVICES[7]		
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)
CHEMICAL DEPENDENCY SERVICES		
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)
OTHER		
Certain durable medical equipment (DME)[8]	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered
Vision exam[3]	$30	$30
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0
Hospice care[3]	$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.

[1]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.
[2]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*).
[3]This service is not subject to a deductible.
[4]Scheduled prenatal visits and the first postpartum visit
[5]23 months or younger
[6]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.
[7]Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.
[8]Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

KAISER PERMANENTE

DEDUCTIBLE HMO PLANS WITH HRA RATE AREA 4

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

$30/$2,500 PLAN WITH HRA[2]

	16 to 50 enrolling employees RAF[1] .90				6 to 15 enrolling employees RAF[1] 1.00				5 or fewer enrolling employees RAF[1] 1.10			
Age	EE only	EE+S	EE+C	EE+S+C	EE only	EE+S	EE+C	EE+S+C	EE only	EE+S	EE+C	EE+S+C
<30	$124	$340	$281	$410	$138	$378	$312	$455	$152	$415	$343	$500
30–39	$146	$391	$295	$458	$163	$435	$329	$509	$179	$478	$361	$560
40–49	$198	$404	$310	$513	$220	$449	$344	$570	$242	$494	$379	$628
50–54	$265	$550	$363	$609	$294	$610	$403	$675	$323	$671	$442	$743
55–59	$328	$682	$425	$748	$365	$759	$473	$832	$401	$834	$520	$914
60–64	$421	$842	$520	$932	$468	$936	$578	$1,036	$514	$1,029	$635	$1,139
65+	$510	$1,163	$605	$1,220	$567	$1,293	$673	$1,356	$624	$1,423	$741	$1,493

$30/$1,500 PLAN WITH HRA[2]

	16 to 50 enrolling employees RAF[1] .90				6 to 15 enrolling employees RAF[1] 1.00				5 or fewer enrolling employees RAF[1] 1.10			
Age	EE only	EE+S	EE+C	EE+S+C	EE only	EE+S	EE+C	EE+S+C	EE only	EE+S	EE+C	EE+S+C
<30	$139	$380	$314	$458	$154	$422	$349	$508	$169	$463	$383	$558
30–39	$164	$438	$331	$513	$182	$486	$367	$569	$200	$535	$404	$626
40–49	$221	$451	$346	$573	$246	$502	$385	$638	$270	$552	$423	$701
50–54	$296	$614	$405	$680	$328	$681	$449	$754	$361	$750	$494	$830
55–59	$367	$763	$476	$836	$408	$848	$529	$930	$449	$933	$582	$1,023
60–64	$470	$941	$581	$1,041	$523	$1,046	$646	$1,157	$575	$1,151	$711	$1,273
65+	$570	$1,300	$677	$1,364	$634	$1,445	$752	$1,516	$697	$1,589	$827	$1,667

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.

[1]Risk adjustment factor

[2]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) MEMBER PAYS	PHCS providers (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE			
Individual/Family	$0	$500/$1,000[1]	
PHARMACY CALENDAR-YEAR DEDUCTIBLE	$0	$0	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM[1,2,3]			
Individual/Family	$3,000/$6,000	$3,000/$9,000	$6,000/$18,000
IN THE MEDICAL OFFICE			
Office visits	$35	$45	50%
Routine adult physical exams	$35	$45	Not covered
Adult preventive screening exam	$35	$45	50%
Maternity/Prenatal care[5]	$0	$25	50%
Well-child preventive care visits	$0[6]	$25[7]	50%[7]
Vaccines (immunizations)	$0	Not covered	Not covered
Allergy injections	$5	$25	50%
Infertility services[8]	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$35	$45[9]	50%[9]
Most labs and imaging	$10	30%	50%
MRI/CT/PET	$50	30%	50%
Outpatient surgery	$100	30%	50%[4]
EMERGENCY SERVICES			
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		
PRESCRIPTIONS (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies)[10]	Obtained at participating MedImpact pharmacies[11]	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
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	$200 per day	30%	50%[13]
Skilled nursing facility care	$0[12]	30%[9]	50%[9,13]
MENTAL HEALTH SERVICES[14]			
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
CHEMICAL DEPENDENCY SERVICES			
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
OTHER			
Certain durable medical equipment (DME)[15]	$0	30%[16]	50%[16]
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%[17]	20%[17]
Hospice care	$0	30%[18]	50%[18]

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 4

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

$35 POS PLAN

16 to 50 enrolling employees RAF[19] .90					6 to 15 enrolling employees RAF[19] 1.00					5 or fewer enrolling employees RAF[19] 1.10				
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	$354	$1,002	$912	$1,304	<30	$393	$1,113	$1,013	$1,449	<30	$432	$1,224	$1,114	$1,593
30–39	$405	$1,112	$949	$1,461	30–39	$451	$1,236	$1,056	$1,624	30–39	$496	$1,360	$1,161	$1,787
40–49	$530	$1,178	$929	$1,516	40–49	$589	$1,309	$1,032	$1,684	40–49	$648	$1,440	$1,136	$1,853
50–54	$698	$1,455	$1,088	$1,772	50–54	$776	$1,618	$1,210	$1,970	50–54	$853	$1,779	$1,330	$2,167
55–59	$874	$1,836	$1,259	$2,091	55–59	$971	$2,040	$1,399	$2,324	55–59	$1,068	$2,243	$1,539	$2,555
60–64	$1,100	$2,131	$1,418	$2,413	60–64	$1,222	$2,367	$1,575	$2,680	60–64	$1,344	$2,604	$1,733	$2,948
65+	$1,330	$2,933	$1,767	$3,062	65+	$1,478	$3,259	$1,963	$3,402	65+	$1,626	$3,585	$2,160	$3,743

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.

[1]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.

[2]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*).

[3]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.

[4]Kaiser Permanente Insurance Company (KPIC) pays a maximum of $400 per procedure for outpatient surgery services from nonparticipating providers.

[5]Scheduled prenatal visits and the first postpartum visit

[6]Well-child care is covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger.

[7]Well-child care (ages 0 to 18) is exempt from deductibles from PHCS network providers and includes immunizations.

[8]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.

[9]All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.

[10]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.

[11]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.

[12]Care in a skilled nursing facility is limited to 100 days per benefit period.

[13]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.

[14]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*.

[15]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.

[16]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.

[17]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.

[18]Hospice care is limited to a 180-day lifetime benefit maximum for services from PHCS network and nonparticipating providers combined.

[19]Risk adjustment factor

HMO exclusions and limitations

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

$40/$2,500 PPO INSURANCE PLAN WITH HSA OPTION PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

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

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

KAISER PERMANENTE
$40/$2,500 PPO INSURANCE PLAN WITH HSA OPTION RATE AREA 4 EFFECTIVE 7/1/09–12/1/09

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

$40/$2,500 PPO INSURANCE PLAN WITH HSA

16 to 50 enrolling employees — RAF[21] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$272	$793	$589	$890
30–39	$336	$937	$653	$1,032
40–49	$449	$990	$688	$1,144
50–54	$605	$1,268	$792	$1,353
55–59	$745	$1,565	$930	$1,647
60–64	$971	$1,942	$1,156	$2,022
65+	$1,208	$2,817	$1,391	$2,892

6 to 15 enrolling employees — RAF[21] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$303	$882	$656	$990
30–39	$373	$1,041	$726	$1,147
40–49	$499	$1,100	$765	$1,271
50–54	$672	$1,409	$880	$1,504
55–59	$828	$1,740	$1,034	$1,831
60–64	$1,079	$2,157	$1,284	$2,246
65+	$1,342	$3,130	$1,546	$3,213

5 or fewer enrolling employees — RAF[21] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$333	$970	$721	$1,089
30–39	$410	$1,145	$798	$1,262
40–49	$549	$1,211	$841	$1,399
50–54	$739	$1,550	$968	$1,654
55–59	$911	$1,914	$1,138	$2,014
60–64	$1,187	$2,373	$1,413	$2,471
65+	$1,476	$3,442	$1,700	$3,533

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.

[1] 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.

[2] Out-of-pocket maximums are separate for services provided by PHCS network and nonparticipating providers.

[3] Maximum benefit amount while insured is combined for services provided by PHCS network and nonparticipating providers.

[4] 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.

[5] This service is not subject to a deductible.

[6] Routine adult physical exams are limited to one exam every 12 months and a benefit maximum of $400 per covered exam.

[7] Well-child preventive care is exempt from deductibles and includes immunizations.

[8] All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

[9] 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.

[10] 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.

[11] 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.

[12] 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.

[13] 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.

[14] 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.

[15] 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.

[16] 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.

[17] 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.

[18] 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.

[19] 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.

[20] Kaiser Permanente Insurance Company pays a maximum of $400 per procedure for outpatient surgery services from nonparticipating providers.

[21] 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)[1] MEMBER PAYS	Nonparticipating providers (out-of-network)[1] MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE[2] Individual/Family	$1,000/$2,000	
ANNUAL OUT-OF-POCKET MAXIMUM[2,3] Individual/Family	$5,000/$10,000	$10,000/$20,000
MAXIMUM BENEFIT WHILE INSURED[4]	$5 million	
HOSPITAL CARE		
Room, board, and critical care units	30%	50%[5]
Imaging, including X-rays and lab tests	30%	50%[5]
Transplants	30%	50%[5]
Physician, surgeon, and surgical services	30%	50%
Nursing care, anesthesia, and inpatient prescribed drugs	30%	50%[5]
OUTPATIENT CARE		
Physician office visits	$40 copay[6,7]	50%
Routine adult physical exams	$40 copay[6,7,8]	Not covered
Adult preventive screening exam	$40 copay[6,7]	50%[7]
Well-child preventive care visits (through age 18)	$25 copay[6,9]	50%[9]
Pediatric visits	$40 copay[6,7]	50%
Outpatient surgery	30%	50%[23]
Allergy testing visits	30%	50%
Allergy injection visits	30%	50%
Gynecological visits	$40 copay[6,7]	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[10]	30%	50%
Diabetic day care management	30%	Not covered
EMERGENCY SERVICES		
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[11]	Covered at the nonparticipating providers level	50%
PRESCRIPTIONS[12]	**MedImpact pharmacy[13]**	**Non–MedImpact pharmacy**
Generic drugs	$15 copay[6] (maximum 30-day supply)	Not covered
Brand-name drugs deductible (pharmacy and mail order)	$200 deductible[6]	Not covered
Brand-name drugs	$35 copay[6] (maximum 30-day supply)	Not covered
Self-administered injectable medications[14]	30%[6]	Not covered
Mail-order generic drugs	$30 copay[6] (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	$70 copay[6] (maximum 100-day supply)	Not covered
MENTAL HEALTH CARE		
Inpatient hospitalization		
Severe mental illness and serious emotional disturbances of a child[15]	30%	50%[5]
All other covered mental illness[16]	30%	50%
Outpatient visits		
Severe mental illness and serious emotional disturbances of a child[15]	$40 copay[6,7]	50%
All other covered mental illness[17]	30%	50%
ALCOHOL AND CHEMICAL DEPENDENCY[18]		
Inpatient hospitalization[16]	30%	50%
Outpatient visits[17]	$40 copay[6]	Not covered
ADDITIONAL BENEFITS		
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)[19]	20%	20%
Hospice care (180-day combined lifetime limit)	30%	50%
Infertility services[20]	30%	50%
Durable medical equipment (DME)[21]	30%	50%
Prosthetics, orthotics, and special footwear	30%	50%
Diabetic equipment and supplies[22]	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.

See footnotes and other important information on pages 15 and 16.

$40/$1,000 PPO INSURANCE PLAN RATE AREA 4

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

$40/$1,000 PPO INSURANCE PLAN

16 to 50 enrolling employees RAF[24] .90

Age	EE only	EE+S	EE+C	EE+S+C
<30	$294	$857	$637	$962
30–39	$363	$1,013	$706	$1,116
40–49	$486	$1,071	$744	$1,237
50–54	$654	$1,371	$856	$1,463
55–59	$806	$1,693	$1,006	$1,781
60–64	$1,050	$2,099	$1,250	$2,185
65+	$1,306	$3,045	$1,504	$3,126

6 to 15 enrolling employees RAF[24] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
<30	$327	$953	$708	$1,070
30–39	$403	$1,125	$784	$1,240
40–49	$540	$1,190	$827	$1,375
50–54	$726	$1,523	$951	$1,625
55–59	$895	$1,880	$1,118	$1,978
60–64	$1,166	$2,332	$1,388	$2,428
65+	$1,451	$3,384	$1,671	$3,474

5 or fewer enrolling employees RAF[24] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
<30	$360	$1,049	$779	$1,177
30–39	$444	$1,239	$863	$1,365
40–49	$594	$1,309	$910	$1,512
50–54	$799	$1,675	$1,046	$1,788
55–59	$985	$2,069	$1,230	$2,177
60–64	$1,283	$2,565	$1,527	$2,670
65+	$1,596	$3,722	$1,838	$3,821

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.

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

[1] 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.

[2] 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.

[3] 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.

[4] Maximum benefit while insured is combined for services provided by PHCS network and nonparticipating providers.

[5] 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.

[6] 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.

[7] This service is not subject to a deductible.

[8] Routine adult physical exams are limited to one exam every 12 months and $400 per calendar year.

[9] Well-child preventive care is exempt from deductibles and includes immunizations.

[10] All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

[11] 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.

[12] 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.

[13] 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.

[14] 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.

[15] 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.

[16] 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.

[17] Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient visits per calendar year.

[18] 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.

[19] Combined maximum deductible of $50 per calendar year

[20] 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.

[21] DME is limited to a maximum of $2,000 per calendar year combined for services provided by PHCS network and nonparticipating providers.

[22] 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.

[23] Kaiser Permanente Insurance Company pays a maximum of $400 per procedure for outpatient surgery services from nonparticipating providers.

[24] 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

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*.

RATE AREA 4

Below is a listing of all ZIP codes within Rate Area 4.

Portions of the following counties are within Rate Area 4: Imperial, Kern, Los Angeles, Riverside, San Bernardino, Tulare, and Ventura.

91701	92252–56	92344–46	92513–19
91708–10	92258	92350	92521–22
91729–30	92260–64	92352	92530–32
91737	92268	92354	92543–46
91739	92270	92357–59	92548
91743	92274–78	92369	92551–57
91752	92282	92371–78	92562–64
91758	92284–86	92382	92567
91761–64	92292	92385–86	92570–72
91784–86	92305	92391–95	92581–87
92201–03	92307–08	92397	92589–93
92210–11	92313–18	92399	92595–96
92220	92320–22	92401–08	92599
92223	92324–26	92410–15	92860
92230	92329	92418	92877–83
92234–36	92331	92423–24	
92240–41	92333–37	92427	
92247–48	92339–41	92501–09	

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