

PLAN HIGHLIGHTS AND RATES

Effective January to June 2010

2010 SMALL BUSINESS RATE AREA 5

WELCOME TO KAISER PERMANENTE

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 2010 Kaiser Foundation Health Plan *Evidence of Coverage* and your Kaiser Permanente Insurance Company *Certificate of Insurance*.

Why not give them a choice?

Keep your employees healthy and happy by letting them choose from a variety of coverage options.

After all, your company runs well because it values the unique skills that each employee brings to the job. Why not offer them the ability to choose the health care plan that best meets their unique needs—and those of their family members? Now, with Kaiser Permanente, you can let your employees choose the plan with the right balance of options for them.

It's a business advantage, too.

You need a simple solution that provides choice at the right price and is easy to administer. Solve the problem by providing a suite of plans from Kaiser Permanente—including a selection of copayment, HSA-qualified, HRA, deductible, POS, and PPO plans for your employees—with no added expense or effort on your part.¹

¹Multiple plan offering rules: Groups with three to five subscribers are eligible to enroll in a maximum of two Kaiser Permanente plans. Groups with six or more subscribers are eligible to enroll in one or more plans. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in an HMO plan, and combined enrollment in Kaiser Permanente Insurance Company (KPIC) POS and PPO plans must not exceed 30 percent.

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The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic benefit is administered by American Specialty Health Plans of California, Inc. The chiropractic/acupuncture benefit is administered by Private Healthcare Systems.

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

KAISER PERMANENTE COPAYMENT PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/10–6/1/10

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
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 MAXIMUM¹ Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,000/\$6,000	\$2,500/\$5,000	\$2,500/\$5,000	\$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
PRESCRIPTIONS⁴	(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 ⁵	\$10	\$10	\$10	\$10	\$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 SERVICES⁶					
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 ⁸	Not covered ⁸	Not covered ⁸	\$150 allowance ⁹	\$150 allowance ⁹
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

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

¹The 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*).

²Scheduled prenatal visits and the first postpartum visit

³Well-child visits through age 23 months

⁴Prescription 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.

⁵This service is not subject to a deductible.

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

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

⁸Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

⁹Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

KAISER PERMANENTE COPAYMENT PLANS RATE AREA 5

EFFECTIVE 1/1/10-6/1/10

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 ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$50 PLAN					\$50 PLAN					\$50 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	\$168	\$469	\$461	\$653	<30	\$186	\$520	\$512	\$724	<30	\$205	\$573	\$563	\$797
30-39	\$185	\$503	\$474	\$720	30-39	\$206	\$560	\$527	\$801	30-39	\$227	\$616	\$580	\$882
40-49	\$239	\$550	\$454	\$726	40-49	\$266	\$612	\$505	\$808	40-49	\$292	\$672	\$555	\$887
50-54	\$311	\$647	\$513	\$827	50-54	\$346	\$719	\$571	\$919	50-54	\$381	\$791	\$628	\$1,011
55-59	\$393	\$826	\$588	\$950	55-59	\$437	\$918	\$653	\$1,056	55-59	\$481	\$1,010	\$719	\$1,162
60-64	\$485	\$922	\$649	\$1,076	60-64	\$539	\$1,024	\$721	\$1,195	60-64	\$593	\$1,127	\$793	\$1,316
65+	\$550	\$1,189	\$827	\$1,307	65+	\$612	\$1,322	\$920	\$1,453	65+	\$673	\$1,454	\$1,012	\$1,598
\$30 PLAN					\$30 PLAN					\$30 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	\$184	\$513	\$505	\$714	<30	\$204	\$570	\$560	\$793	<30	\$224	\$626	\$616	\$871
30-39	\$203	\$551	\$519	\$789	30-39	\$225	\$612	\$576	\$876	30-39	\$248	\$674	\$634	\$964
40-49	\$262	\$602	\$497	\$794	40-49	\$291	\$669	\$553	\$883	40-49	\$320	\$736	\$608	\$971
50-54	\$340	\$707	\$561	\$904	50-54	\$378	\$786	\$624	\$1,005	50-54	\$416	\$865	\$686	\$1,106
55-59	\$430	\$903	\$643	\$1,039	55-59	\$478	\$1,004	\$715	\$1,155	55-59	\$526	\$1,104	\$786	\$1,270
60-64	\$531	\$1,008	\$710	\$1,177	60-64	\$590	\$1,120	\$789	\$1,307	60-64	\$649	\$1,232	\$868	\$1,438
65+	\$602	\$1,301	\$905	\$1,430	65+	\$669	\$1,445	\$1,006	\$1,589	65+	\$736	\$1,590	\$1,106	\$1,748
\$20 PLAN					\$20 PLAN					\$20 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	\$201	\$561	\$551	\$780	<30	\$223	\$623	\$612	\$867	<30	\$245	\$685	\$673	\$953
30-39	\$222	\$602	\$567	\$862	30-39	\$246	\$669	\$629	\$958	30-39	\$271	\$736	\$692	\$1,053
40-49	\$286	\$658	\$543	\$868	40-49	\$318	\$731	\$604	\$965	40-49	\$349	\$803	\$663	\$1,060
50-54	\$372	\$773	\$614	\$988	50-54	\$413	\$859	\$681	\$1,098	50-54	\$455	\$945	\$750	\$1,208
55-59	\$470	\$987	\$703	\$1,135	55-59	\$522	\$1,097	\$780	\$1,262	55-59	\$575	\$1,207	\$859	\$1,388
60-64	\$580	\$1,102	\$776	\$1,286	60-64	\$644	\$1,224	\$861	\$1,429	60-64	\$709	\$1,346	\$948	\$1,571
65+	\$658	\$1,421	\$989	\$1,562	65+	\$731	\$1,579	\$1,099	\$1,736	65+	\$804	\$1,737	\$1,209	\$1,909
\$15 PLAN					\$15 PLAN					\$15 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	\$220	\$615	\$605	\$856	<30	\$245	\$684	\$673	\$952	<30	\$269	\$752	\$740	\$1,047
30-39	\$244	\$662	\$623	\$947	30-39	\$271	\$736	\$692	\$1,053	30-39	\$298	\$809	\$761	\$1,158
40-49	\$314	\$723	\$597	\$954	40-49	\$349	\$803	\$663	\$1,060	40-49	\$384	\$884	\$730	\$1,167
50-54	\$409	\$850	\$674	\$1,087	50-54	\$454	\$944	\$749	\$1,207	50-54	\$500	\$1,039	\$824	\$1,328
55-59	\$517	\$1,085	\$773	\$1,248	55-59	\$574	\$1,206	\$858	\$1,387	55-59	\$632	\$1,327	\$945	\$1,526
60-64	\$637	\$1,210	\$852	\$1,413	60-64	\$708	\$1,345	\$947	\$1,570	60-64	\$779	\$1,480	\$1,042	\$1,728
65+	\$723	\$1,562	\$1,087	\$1,717	65+	\$803	\$1,736	\$1,207	\$1,908	65+	\$884	\$1,910	\$1,329	\$2,100
\$5 PLAN					\$5 PLAN					\$5 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	\$274	\$765	\$752	\$1,064	<30	\$304	\$849	\$835	\$1,182	<30	\$335	\$935	\$919	\$1,301
30-39	\$302	\$821	\$773	\$1,175	30-39	\$336	\$913	\$859	\$1,307	30-39	\$370	\$1,005	\$945	\$1,438
40-49	\$390	\$898	\$741	\$1,185	40-49	\$434	\$998	\$824	\$1,317	40-49	\$477	\$1,097	\$906	\$1,448
50-54	\$508	\$1,056	\$838	\$1,350	50-54	\$564	\$1,173	\$930	\$1,499	50-54	\$621	\$1,290	\$1,024	\$1,649
55-59	\$642	\$1,348	\$960	\$1,550	55-59	\$713	\$1,497	\$1,066	\$1,722	55-59	\$784	\$1,647	\$1,172	\$1,894
60-64	\$792	\$1,504	\$1,059	\$1,756	60-64	\$879	\$1,670	\$1,176	\$1,950	60-64	\$967	\$1,837	\$1,293	\$2,145
65+	\$898	\$1,940	\$1,350	\$2,133	65+	\$997	\$2,155	\$1,499	\$2,369	65+	\$1,097	\$2,371	\$1,649	\$2,606

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.

¹Risk adjustment factor

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/10–6/1/10

FEATURES	MOST POPULAR DEDUCTIBLE PLAN		
	\$30/\$3,000 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,000 PLAN W/HSA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$3,000/\$6,000 ¹	\$2,700/\$5,450 ¹	\$2,000/\$4,000 ²
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM³ Individual/Family	\$5,950/\$11,900 ¹	\$4,500/\$9,000 ¹	\$3,500/\$7,000 ²
IN THE MEDICAL OFFICE Office visits Preventive exams ⁴ Maternity/Prenatal care ^{4,5} Well-child preventive care visits ^{4,6} Vaccines (immunizations) ⁴ 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) \$50 (after deductible) \$250 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$50 (after deductible) \$150 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)
PRESCRIPTIONS⁷ Generic Brand-name	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)
HOSPITAL CARE 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)	\$450 per day (after deductible) \$0 per admission (after deductible)	\$300 per day (after deductible) \$0 per admission (after deductible)
MENTAL HEALTH SERVICES⁸ 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) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$300 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES 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) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$300 per day (after deductible)
OTHER Certain durable medical equipment (DME) ⁹ Optical (eyewear) ¹⁰ 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)

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

¹This 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.

²This 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.

³The 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*).

⁴This service is not subject to a deductible.

⁵Scheduled prenatal visits

⁶Well-child visits through age 23 months

⁷Prescription 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.

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

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

¹⁰Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS RATE AREA 5

EFFECTIVE 1/1/10-6/1/10

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 ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$3,000 PLAN WITH HSA					\$30/\$3,000 PLAN WITH HSA					\$30/\$3,000 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	\$92	\$251	\$208	\$302	<30	\$102	\$279	\$231	\$336	<30	\$112	\$307	\$253	\$370
30-39	\$108	\$289	\$218	\$338	30-39	\$120	\$321	\$242	\$376	30-39	\$132	\$353	\$267	\$413
40-49	\$146	\$298	\$229	\$379	40-49	\$163	\$332	\$255	\$422	40-49	\$179	\$365	\$280	\$464
50-54	\$195	\$405	\$267	\$448	50-54	\$217	\$451	\$297	\$499	50-54	\$239	\$496	\$327	\$549
55-59	\$243	\$505	\$315	\$554	55-59	\$270	\$561	\$350	\$615	55-59	\$297	\$617	\$385	\$676
60-64	\$311	\$622	\$384	\$688	60-64	\$345	\$691	\$427	\$765	60-64	\$380	\$761	\$470	\$842
65+	\$377	\$860	\$447	\$902	65+	\$419	\$955	\$497	\$1,002	65+	\$461	\$1,051	\$547	\$1,103
\$0/\$2,700 PLAN WITH HSA					\$0/\$2,700 PLAN WITH HSA					\$0/\$2,700 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	\$104	\$284	\$235	\$342	<30	\$115	\$315	\$260	\$380	<30	\$127	\$347	\$287	\$418
30-39	\$122	\$327	\$247	\$383	30-39	\$136	\$363	\$274	\$425	30-39	\$149	\$399	\$301	\$467
40-49	\$165	\$337	\$258	\$428	40-49	\$184	\$375	\$288	\$476	40-49	\$202	\$412	\$316	\$524
50-54	\$221	\$459	\$303	\$508	50-54	\$245	\$509	\$336	\$564	50-54	\$270	\$560	\$370	\$620
55-59	\$274	\$570	\$355	\$625	55-59	\$305	\$634	\$395	\$695	55-59	\$335	\$697	\$434	\$764
60-64	\$351	\$703	\$434	\$778	60-64	\$390	\$781	\$482	\$864	60-64	\$429	\$859	\$530	\$951
65+	\$426	\$972	\$506	\$1,020	65+	\$474	\$1,080	\$562	\$1,133	65+	\$521	\$1,188	\$618	\$1,246
\$0/\$2,000 PLAN WITH HSA					\$0/\$2,000 PLAN WITH HSA					\$0/\$2,000 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	\$134	\$367	\$304	\$442	<30	\$149	\$408	\$338	\$492	<30	\$164	\$449	\$371	\$541
30-39	\$159	\$424	\$321	\$496	30-39	\$176	\$471	\$355	\$551	30-39	\$194	\$518	\$391	\$606
40-49	\$214	\$437	\$335	\$555	40-49	\$238	\$486	\$372	\$618	40-49	\$262	\$535	\$410	\$680
50-54	\$286	\$594	\$392	\$658	50-54	\$318	\$661	\$436	\$732	50-54	\$350	\$727	\$479	\$805
55-59	\$356	\$740	\$461	\$811	55-59	\$395	\$822	\$512	\$901	55-59	\$435	\$904	\$564	\$991
60-64	\$456	\$912	\$564	\$1,009	60-64	\$506	\$1,013	\$626	\$1,121	60-64	\$557	\$1,115	\$689	\$1,234
65+	\$553	\$1,261	\$656	\$1,323	65+	\$614	\$1,400	\$729	\$1,469	65+	\$676	\$1,541	\$802	\$1,617

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.

¹Risk adjustment factor

KAISER PERMANENTE DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/10-6/1/10

FEATURES	\$40/\$2,000 PLAN MEMBER PAYS	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,000 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,000/\$4,000	\$1,500/\$3,000	\$1,000/\$2,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM^{1,2} Individual/Family	\$4,500/\$9,000	\$3,500/\$7,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE			
Office visits ³	\$40	\$30	\$30
Preventive exams ³	\$40	\$30	\$30
Maternity/Prenatal care ^{3,4}	\$0	\$0	\$0
Well-child preventive care visits ^{3,5}	\$0	\$0	\$0
Vaccines (immunizations) ³	\$0	\$0	\$0
Allergy injections	\$5 (after deductible)	\$5 (after deductible)	\$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$40 (after deductible)	\$30 (after deductible)	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	30% (after deductible)	\$250 (after deductible)	\$250 (after deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	30% (after deductible)	\$100 (after deductible)	\$100 (after deductible)
Ambulance	\$100 (after deductible)	\$75 (after deductible)	\$75 (after deductible)
PRESCRIPTIONS^{3,6}	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	\$10	\$10	\$10
Brand-name	\$35	\$30	\$30
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
Skilled nursing facility care (up to 60 days per benefit period)	30% per admission (after deductible)	\$50 per day (after deductible)	\$50 per day (after deductible)
MENTAL HEALTH SERVICES⁷			
In the medical office ³ (up to 20 visits per calendar year)	\$40 (for individual therapy) \$20 (for group therapy)	\$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)	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office ³	\$40 (for individual therapy)	\$30 (for individual therapy)	\$30 (for individual therapy)
In the hospital (detoxification only)	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
OTHER			
Certain durable medical equipment (DME) ⁸	30% per item	Not covered	Not covered
Optical (eyewear) ⁹	Not covered	Not covered	Not covered
Vision exam ³	\$40	\$30	\$30
Home health care ³ (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0
Hospice care ³	\$0	\$0	\$0

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

¹This 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.

²The 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*).

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

⁶Prescription 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.

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

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

⁹Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

KAISER PERMANENTE DEDUCTIBLE HMO PLANS RATE AREA 5

EFFECTIVE 1/1/10-6/1/10

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 ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$40/\$2,000 PLAN					\$40/\$2,000 PLAN					\$40/\$2,000 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	\$118	\$322	\$267	\$388	<30	\$131	\$358	\$296	\$431	<30	\$144	\$394	\$326	\$475
30-39	\$139	\$371	\$280	\$434	30-39	\$154	\$412	\$311	\$482	30-39	\$170	\$454	\$343	\$531
40-49	\$188	\$383	\$294	\$487	40-49	\$209	\$426	\$327	\$541	40-49	\$229	\$468	\$358	\$595
50-54	\$251	\$521	\$344	\$577	50-54	\$279	\$579	\$382	\$641	50-54	\$306	\$636	\$419	\$704
55-59	\$311	\$647	\$403	\$709	55-59	\$346	\$719	\$449	\$788	55-59	\$381	\$792	\$494	\$868
60-64	\$399	\$798	\$493	\$883	60-64	\$443	\$887	\$548	\$981	60-64	\$488	\$976	\$603	\$1,080
65+	\$484	\$1,103	\$574	\$1,157	65+	\$538	\$1,226	\$638	\$1,286	65+	\$591	\$1,348	\$701	\$1,414
\$30/\$1,500 PLAN					\$30/\$1,500 PLAN					\$30/\$1,500 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	\$126	\$346	\$286	\$417	<30	\$140	\$384	\$317	\$463	<30	\$154	\$423	\$349	\$510
30-39	\$149	\$399	\$301	\$467	30-39	\$166	\$443	\$335	\$519	30-39	\$182	\$487	\$368	\$570
40-49	\$202	\$412	\$316	\$523	40-49	\$224	\$457	\$351	\$581	40-49	\$247	\$504	\$386	\$640
50-54	\$270	\$560	\$370	\$620	50-54	\$300	\$622	\$411	\$689	50-54	\$330	\$685	\$452	\$758
55-59	\$335	\$696	\$434	\$763	55-59	\$372	\$773	\$482	\$847	55-59	\$409	\$851	\$530	\$933
60-64	\$429	\$859	\$530	\$950	60-64	\$477	\$954	\$590	\$1,056	60-64	\$524	\$1,049	\$648	\$1,161
65+	\$520	\$1,186	\$617	\$1,244	65+	\$578	\$1,318	\$686	\$1,383	65+	\$636	\$1,450	\$755	\$1,521
\$30/\$1,000 PLAN					\$30/\$1,000 PLAN					\$30/\$1,000 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	\$143	\$391	\$324	\$471	<30	\$159	\$435	\$360	\$524	<30	\$175	\$479	\$396	\$577
30-39	\$169	\$451	\$341	\$528	30-39	\$188	\$502	\$379	\$588	30-39	\$206	\$551	\$416	\$645
40-49	\$228	\$466	\$357	\$592	40-49	\$254	\$518	\$397	\$658	40-49	\$279	\$569	\$436	\$723
50-54	\$305	\$633	\$418	\$701	50-54	\$339	\$703	\$464	\$778	50-54	\$373	\$774	\$511	\$857
55-59	\$378	\$787	\$490	\$863	55-59	\$420	\$874	\$545	\$958	55-59	\$463	\$962	\$600	\$1,054
60-64	\$485	\$971	\$600	\$1,074	60-64	\$539	\$1,079	\$666	\$1,194	60-64	\$593	\$1,187	\$733	\$1,313
65+	\$588	\$1,341	\$698	\$1,407	65+	\$654	\$1,491	\$776	\$1,564	65+	\$719	\$1,639	\$853	\$1,719

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.

¹Risk adjustment factor

KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA PLAN HIGHLIGHTS

EFFECTIVE 1/1/10–6/1/10

FEATURES	\$30/\$2,500 PLAN WITH HRA MEMBER PAYS	\$30/\$1,500 PLAN WITH HRA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,500/\$5,000	\$1,500/\$3,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM^{1,2} Individual/Family	\$5,000/\$10,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE Office visits Preventive exams ³ Maternity/Prenatal care ^{3,4} Well-child preventive care visits ^{3,5} Vaccines (immunizations) ³ 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 \$0 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 20% (after deductible)	\$30 (after deductible) \$30 \$10 \$10 \$0 \$0 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 20% (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	20% (after deductible) \$150 (after deductible)	20% (after deductible) \$150 (after deductible)
PRESCRIPTIONS⁶ Generic ³ Brand-name	(up to a 30-day supply) \$10 \$30	(up to a 30-day supply) \$10 \$30
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care	20% per admission (after deductible) 20% per day (after deductible) (up to 100 days per benefit period)	20% per admission (after deductible) 20% per day (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES⁷ 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) 20% per admission (after deductible)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 20% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 20% per admission (after deductible)	\$30 (after deductible for individual therapy) 20% per admission (after deductible)
OTHER Certain durable medical equipment (DME) ⁸ Optical (eyewear) ⁹ Vision exam ³ Home health care ³ (up to 100 two-hour visits per calendar year) Hospice care ³	Not covered Not covered \$30 \$0 \$0	Not covered Not covered \$30 \$0 \$0

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

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.

¹This 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.

²The 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*).

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

⁶Prescription 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.

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

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

⁹Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA RATE AREA 5

EFFECTIVE 1/1/10-6/1/10

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 ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$2,500 PLAN WITH HRA ²					\$30/\$2,500 PLAN WITH HRA ²					\$30/\$2,500 PLAN WITH HRA ²				
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	\$116	\$318	\$263	\$383	<30	\$129	\$354	\$292	\$427	<30	\$142	\$389	\$322	\$469
30-39	\$137	\$367	\$277	\$430	30-39	\$153	\$408	\$309	\$478	30-39	\$168	\$449	\$339	\$526
40-49	\$186	\$379	\$291	\$482	40-49	\$206	\$421	\$322	\$535	40-49	\$227	\$463	\$355	\$588
50-54	\$248	\$515	\$340	\$570	50-54	\$276	\$573	\$378	\$634	50-54	\$303	\$629	\$415	\$696
55-59	\$308	\$641	\$399	\$703	55-59	\$342	\$712	\$443	\$780	55-59	\$377	\$783	\$489	\$858
60-64	\$395	\$790	\$488	\$874	60-64	\$439	\$878	\$543	\$972	60-64	\$483	\$966	\$597	\$1,069
65+	\$479	\$1,092	\$568	\$1,146	65+	\$532	\$1,213	\$631	\$1,272	65+	\$585	\$1,334	\$694	\$1,399
\$30/\$1,500 PLAN WITH HRA ²					\$30/\$1,500 PLAN WITH HRA ²					\$30/\$1,500 PLAN WITH HRA ²				
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	\$130	\$356	\$294	\$429	<30	\$144	\$395	\$326	\$476	<30	\$159	\$435	\$360	\$524
30-39	\$154	\$411	\$310	\$481	30-39	\$171	\$456	\$345	\$534	30-39	\$188	\$502	\$379	\$588
40-49	\$208	\$424	\$325	\$539	40-49	\$231	\$471	\$361	\$598	40-49	\$254	\$518	\$397	\$658
50-54	\$277	\$575	\$379	\$637	50-54	\$308	\$640	\$422	\$708	50-54	\$339	\$704	\$464	\$779
55-59	\$344	\$716	\$446	\$785	55-59	\$383	\$796	\$496	\$873	55-59	\$421	\$875	\$546	\$959
60-64	\$441	\$883	\$545	\$977	60-64	\$490	\$981	\$606	\$1,085	60-64	\$539	\$1,079	\$666	\$1,194
65+	\$535	\$1,220	\$635	\$1,280	65+	\$595	\$1,356	\$706	\$1,422	65+	\$654	\$1,491	\$776	\$1,564

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.

¹Risk adjustment factor

²Rates do not include contributions to the HRA plan. Administrative fees apply.

KAISER PERMANENTE \$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 1/1/10–6/1/10

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$0	\$500/\$1,500	
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM^{2,3} Individual/Family	\$3,000/\$6,000	\$3,000/\$9,000 ⁴	\$6,000/\$18,000 ⁴
MAXIMUM BENEFIT WHILE INSURED	Unlimited	\$2 million ⁵	
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 ⁶	\$0	\$25	50%
Well-child preventive care visits	\$0 ⁷	\$25 ⁸	50% ⁸
Vaccines (immunizations)	\$0	Not covered	Not covered
Allergy injections	\$5	\$25	50%
Infertility services ⁹	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$35	\$45 ¹⁰	50% ¹⁰
Most labs and imaging	\$10	30%	50%
MRI/CT/PET	\$50	30%	50%
Outpatient surgery	\$100	30%	50% ¹¹
EMERGENCY SERVICES		Emergency Department visits and ambulance for emergency medical conditions are covered as an HMO benefit for services received at any provider.	
Emergency Department visits (waived if admitted directly to hospital)	\$100		
Ambulance	\$75		
PRESCRIPTIONS¹² (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies)	Obtained at participating MedImpact pharmacies ¹³	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% ¹⁵
Skilled nursing facility care ¹⁴	\$0	30%	50%
MENTAL HEALTH SERVICES¹⁶			
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) ¹⁷	\$0	30% ¹⁸	50% ¹⁸
Prosthetics, orthotics, and special footwear	\$40	Not covered	Not covered
Optical (eyewear)	Not covered ¹⁹	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% ²⁰	20% ²⁰
Hospice care	\$0	30% ²¹	50% ²¹

For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

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

KAISER PERMANENTE \$35 POS PLAN RATE AREA 5

EFFECTIVE 1/1/10–6/1/10

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 ²² .90					6 to 15 enrolling employees RAF ²² 1.00					5 or fewer enrolling employees RAF ²² 1.10				
\$35 POS PLAN					\$35 POS PLAN					\$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	\$336	\$952	\$866	\$1,239	<30	\$373	\$1,057	\$962	\$1,376	<30	\$411	\$1,163	\$1,059	\$1,514
30–39	\$385	\$1,056	\$902	\$1,388	30–39	\$428	\$1,174	\$1,002	\$1,542	30–39	\$471	\$1,292	\$1,103	\$1,697
40–49	\$503	\$1,119	\$882	\$1,440	40–49	\$559	\$1,243	\$980	\$1,600	40–49	\$615	\$1,368	\$1,078	\$1,760
50–54	\$663	\$1,383	\$1,034	\$1,684	50–54	\$737	\$1,536	\$1,149	\$1,871	50–54	\$811	\$1,690	\$1,264	\$2,058
55–59	\$830	\$1,744	\$1,196	\$1,987	55–59	\$923	\$1,938	\$1,330	\$2,208	55–59	\$1,015	\$2,132	\$1,462	\$2,429
60–64	\$1,045	\$2,024	\$1,347	\$2,292	60–64	\$1,161	\$2,249	\$1,497	\$2,546	60–64	\$1,277	\$2,474	\$1,646	\$2,801
65+	\$1,264	\$2,787	\$1,679	\$2,909	65+	\$1,404	\$3,096	\$1,865	\$3,232	65+	\$1,545	\$3,406	\$2,052	\$3,556

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
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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.

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.

- ¹Deductible 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.
- ²The 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*). A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.
- ³Covered 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.
- ⁴The family out-of-pocket maximum equals three times the individual out-of-pocket maximum for family contracts of three or more members. Family contracts with two members will require each member to satisfy the individual out-of-pocket maximum.
- ⁵Maximum benefit while insured is \$2 million combined for services provided by PHCS network and nonparticipating providers.
- ⁶Scheduled prenatal visits and the first postpartum visit.
- ⁷Well-child care is covered by Kaiser Permanente Plan providers (HMO) through age 23 months.
- ⁸Well-child care (ages 0 to 18) is exempt from deductibles from PHCS network providers and includes immunizations.
- ⁹In 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.
- ¹⁰All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.
- ¹¹Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.
- ¹²A 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.
- ¹³Participating 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.
- ¹⁴Care in a skilled nursing facility is limited to 100 days per benefit period.
- ¹⁵Kaiser 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.
- ¹⁶Visit 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*.
- ¹⁷Please refer to the *Evidence of Coverage* and the *Certificate of Insurance* for more information. 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.
- ¹⁸Durable 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.
- ¹⁹Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.
- ²⁰Home 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.
- ²¹Hospice care is limited to a 180-day lifetime benefit maximum for services from PHCS network and nonparticipating providers combined.
- ²²Risk adjustment factor

HMO exclusions and limitations

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

KAISER PERMANENTE
\$40/\$2,500 PPO INSURANCE PLAN WITH HSA OPTION **PLAN HIGHLIGHTS** EFFECTIVE 1/1/10–6/1/10

FEATURES	PHCS network (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,500/\$5,000	\$3,500/\$7,000
ANNUAL OUT-OF-POCKET MAXIMUM² Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
MAXIMUM BENEFIT WHILE INSURED³	\$5 million	
HOSPITAL CARE 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% ⁴ 50% ⁴ 50% ⁴ 50% 50% ⁴
OUTPATIENT CARE Physician office visits Routine adult physical exams Adult preventive screening exam ⁵ Well-child preventive care visits (through age 18) ⁷ 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 ⁹ Diabetic day care management	\$40 copay \$40 copay ^{5,6} \$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% ⁸ 50% 50% 50% 50% 50% 50% Not covered Not covered 50%
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service ¹⁰ Nonemergency urgent care	\$100 copay, then 30% (copay waived if admitted) 30% 30% 30%	\$100 copay, then 30% (copay waived if admitted) 30% 30% 30%
PRESCRIPTIONS¹¹ Generic drugs Brand-name drugs Self-administered injectable medications ¹³ Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹² \$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)	Non-MedImpact pharmacy Not covered Not covered Not covered Not covered Not covered
MENTAL HEALTH CARE Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child ¹⁴ All other covered mental illness ¹⁵ Outpatient visits Severe mental illness and serious emotional disturbances of a child ¹⁴ All other covered mental illness ¹⁶	30% 30% \$40 copay 30%	50% ⁴ 50% 50% 50%
ALCOHOL AND CHEMICAL DEPENDENCY¹⁷ Inpatient hospitalization ¹⁵ Outpatient visits ¹⁶	30% 30%	50% 50%
ADDITIONAL BENEFITS 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 ¹⁸ Durable medical equipment (DME) ¹⁹ Prosthetics, orthotics, and special footwear Diabetic equipment and supplies ²⁰	30% 20% 30% 30% 30% 30% 30%	50% 20% Not covered 50% 50% 50% 30%

For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

KAISER PERMANENTE \$40/\$2,500 PPO INSURANCE PLAN WITH HSA OPTION RATE AREA 5 EFFECTIVE 1/1/10-6/1/10

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

16 to 50 enrolling employees RAF ²¹ .90					6 to 15 enrolling employees RAF ²¹ 1.00					5 or fewer enrolling employees RAF ²¹ 1.10				
\$40/\$2,500 PPO INSURANCE PLAN WITH HSA					\$40/\$2,500 PPO INSURANCE PLAN WITH HSA					\$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	\$287	\$837	\$622	\$939	<30	\$319	\$930	\$691	\$1,044	<30	\$351	\$1,023	\$760	\$1,148
30-39	\$354	\$989	\$689	\$1,090	30-39	\$394	\$1,099	\$766	\$1,211	30-39	\$433	\$1,209	\$842	\$1,332
40-49	\$474	\$1,045	\$726	\$1,207	40-49	\$527	\$1,162	\$807	\$1,342	40-49	\$579	\$1,277	\$887	\$1,475
50-54	\$638	\$1,338	\$835	\$1,428	50-54	\$709	\$1,486	\$928	\$1,586	50-54	\$780	\$1,635	\$1,021	\$1,745
55-59	\$786	\$1,652	\$982	\$1,738	55-59	\$874	\$1,836	\$1,091	\$1,932	55-59	\$961	\$2,019	\$1,200	\$2,124
60-64	\$1,024	\$2,048	\$1,219	\$2,132	60-64	\$1,138	\$2,276	\$1,354	\$2,370	60-64	\$1,252	\$2,503	\$1,490	\$2,606
65+	\$1,274	\$2,971	\$1,468	\$3,050	65+	\$1,416	\$3,302	\$1,631	\$3,389	65+	\$1,558	\$3,633	\$1,795	\$3,729

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.

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.

¹Calendar-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.

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

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

⁴Kaiser 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.

⁵This service is not subject to a deductible.

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

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

⁸Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

⁹All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

¹⁰The 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.

¹¹Member 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.

¹²MedImpact 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.

¹³Self-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.

¹⁴Severe 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.

¹⁵Benefits 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.

¹⁶Benefits 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.

¹⁷In 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.

¹⁸Benefits 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 any other illness.

¹⁹Durable 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.

²⁰Diabetic 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.

²¹Risk 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 1/1/10-6/1/10

PHCS network
(PPO)*

Nonparticipating providers
(out-of-network)*

FEATURES	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family		\$1,000/\$2,000
ANNUAL OUT-OF-POCKET MAXIMUM^{1,2} Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
MAXIMUM BENEFIT WHILE INSURED³		\$5 million
HOSPITAL CARE 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% ⁴ 50% ⁴ 50% ⁴ 50% 50% ⁴
OUTPATIENT CARE Physician office visits Routine adult physical exams Adult preventive screening exam Well-child preventive care visits (through age 18) 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 ¹⁰ Diabetic day care management	\$40 copay ^{5,6} \$40 copay ^{5,6,7} \$40 copay ^{5,6} \$25 copay ^{5,8} \$40 copay ^{5,6} 30% 30% 30% \$40 copay ^{5,6} 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% ⁶ 50% ⁸ 50% 50% ⁹ 50% 50% 50% 50% 50% 50% Not covered Not covered Not covered 50% Not covered
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service ¹¹	\$100 copay, then 30% (copay waived if admitted) Covered at the nonparticipating providers level Covered at the nonparticipating providers level	\$100 copay, then 30% (copay waived if admitted) 30% 30%
PRESCRIPTIONS¹² Generic drugs Brand-name drugs deductible (pharmacy and mail order) Brand-name drugs Self-administered injectable medications ¹⁴ Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹³ \$15 copay ⁵ (maximum 30-day supply) \$200 deductible ⁵ \$35 copay ⁵ (maximum 30-day supply) 30% ⁵ \$30 copay ⁵ (maximum 100-day supply) \$70 copay ⁵ (maximum 100-day supply)	Non-MedImpact pharmacy Not covered Not covered Not covered Not covered Not covered Not covered
MENTAL HEALTH CARE Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child ¹⁵ All other covered mental illness ¹⁶ Outpatient visits Severe mental illness and serious emotional disturbances of a child ¹⁵ All other covered mental illness ¹⁷	30% 30% \$40 copay ^{5,6} 30%	50% ⁴ 50% 50% 50%
ALCOHOL AND CHEMICAL DEPENDENCY¹⁸ Inpatient hospitalization ¹⁶ Outpatient visits ¹⁷	30% \$40 copay ⁵	50% Not covered
ADDITIONAL BENEFITS Care in a skilled nursing facility (60-day combined limit per calendar year) Home health care (100-day combined limit per calendar year) ¹⁹ Hospice care (180-day combined lifetime limit) Infertility services ²⁰ Durable medical equipment (DME) ²¹ Prosthetics, orthotics, and special footwear Diabetic equipment and supplies ²²	30% 20% 30% 30% 30% 30% 30%	50% 20% 50% 50% 50% 50% 30%

For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

KAISER PERMANENTE \$40/\$1,000 PPO INSURANCE PLAN RATE AREA 5

EFFECTIVE 1/1/10–6/1/10

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 ²³ .90					6 to 15 enrolling employees RAF ²³ 1.00					5 or fewer enrolling employees RAF ²³ 1.10				
\$40/\$1,000 PPO INSURANCE PLAN					\$40/\$1,000 PPO INSURANCE PLAN					\$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	\$311	\$905	\$673	\$1,016	<30	\$345	\$1,005	\$747	\$1,128	<30	\$380	\$1,107	\$822	\$1,242
30–39	\$383	\$1,069	\$745	\$1,178	30–39	\$426	\$1,188	\$828	\$1,309	30–39	\$468	\$1,306	\$910	\$1,439
40–49	\$512	\$1,129	\$785	\$1,304	40–49	\$569	\$1,255	\$872	\$1,450	40–49	\$626	\$1,381	\$959	\$1,595
50–54	\$690	\$1,446	\$903	\$1,543	50–54	\$766	\$1,607	\$1,003	\$1,715	50–54	\$843	\$1,768	\$1,104	\$1,887
55–59	\$850	\$1,786	\$1,061	\$1,879	55–59	\$944	\$1,984	\$1,179	\$2,087	55–59	\$1,039	\$2,183	\$1,297	\$2,297
60–64	\$1,107	\$2,214	\$1,318	\$2,305	60–64	\$1,230	\$2,460	\$1,464	\$2,561	60–64	\$1,353	\$2,706	\$1,610	\$2,817
65+	\$1,378	\$3,213	\$1,587	\$3,298	65+	\$1,531	\$3,570	\$1,763	\$3,665	65+	\$1,684	\$3,927	\$1,940	\$4,031

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
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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.

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.

¹Calendar-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.

²Covered 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.

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

⁴Kaiser 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.

⁵Brand-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.

⁶This service is not subject to a deductible.

⁷Routine adult physical exams are limited to one exam every 12 months and \$400 per calendar year.

⁸Well-child preventive care is exempt from deductibles and includes immunizations.

⁹Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

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

¹¹The 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.

¹²Member 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.

¹³MedImpact 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.

¹⁴Self-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.

¹⁵Severe 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.

¹⁶Benefits 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.

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

¹⁸In 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.

¹⁹Combined maximum deductible of \$50 per calendar year

²⁰Benefits 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 any other illness.

²¹Durable 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.

²²Diabetic 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.

²³Risk 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.

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic benefit is administered by American Specialty Health Plans of California, Inc. The chiropractic/acupuncture benefit is administered by Private Healthcare Systems.

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*.

Below is a listing of all ZIP codes within Rate Area 5.

Portions of the following counties
are within Rate Area 5: Los Angeles
and San Diego.

90001-84	90731-34	91214	92013-14
90086-91	90744-49	91221-22	92018-27
90093-96	90755	91224-26	92029-30
90101	90801-10	91501-08	92033
90103	90813-15	91510	92037-40
90189	90822	91521-23	92046
90201-02	90831-35	91702	92049
90209-13	90840	91706	92051-52
90220-24	90842	91711	92054-58
90230-33	90844	91715-16	92064-65
90239-42	90846-48	91722-24	92067-69
90245	90853	91731-35	92071-72
90247-51	90895	91740-41	92074-75
90254-55	91001	91744-50	92078-79
90260-67	91003	91754-56	92081-85
90270	91006-12	91759	92090-93
90272	91016-17	91765-73	92096
90274-75	91020-21	91775-76	92101-24
90277-78	91023-25	91778	92126-32
90280	91030-31	91780	92134-40
90290-96	91040-43	91788-93	92142-43
90301-10	91046	91795	92145
90312	91066	91801-03	92147
90401-11	91077	91901-03	92149-50
90501-10	91101-10	91908-17	92152-55
90601-10	91114-18	91921	92158-79
90637-40	91121	91931-33	92182
90650-52	91123-26	91935	92184
90660-62	91129	91941-47	92186-87
90670	91182	91950-51	92190-93
90701-03	91184-85	91962-63	92195-99
90706-07	91188-89	91976-80	
90710-17	91199	91987	
90723	91201-10	92007-11	

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