

PLAN HIGHLIGHTS AND RATES

Effective July to December 2009

2009 SMALL BUSINESS RATE AREA 5

- 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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Predictable out-of-pocket costs and no annual deductible to meet for medical appointments

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Lower monthly premiums, no deductibles on most doctor's office visits, and moderate deductibles on most other services

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An IRS-regulated, employer-sponsored program that allows your employees to receive tax-free dollars¹ from you to pay for covered medical expenses

\$35 POS Plan

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Flexibility to choose physicians and services inside or outside the Kaiser Permanente network

\$40/\$2,500 PPO Insurance Plan with HSA Option

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Our HSA-option PPO offers the flexibility of a PPO along with lower monthly premiums and optional employee-owned savings accounts.

\$40/\$1,000 PPO Insurance Plan

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Choose a physician from a contracted network or any licensed nonparticipating provider.

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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 7/1/09–12/1/09

FEATURES	MOST POPULAR COPAYMENT PLAN				
	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
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 MAXIMUM¹ 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
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	\$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 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	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.

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

³23 months or younger

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.

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

KAISER PERMANENTE COPAYMENT PLANS RATE AREA 5

EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$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	\$165	\$461	\$453	\$642	<30	\$183	\$512	\$503	\$713	<30	\$202	\$564	\$554	\$785
30-39	\$182	\$495	\$466	\$709	30-39	\$203	\$551	\$518	\$788	30-39	\$223	\$606	\$570	\$867
40-49	\$235	\$541	\$447	\$714	40-49	\$261	\$601	\$496	\$793	40-49	\$287	\$661	\$546	\$872
50-54	\$306	\$636	\$505	\$813	50-54	\$340	\$707	\$561	\$904	50-54	\$374	\$778	\$617	\$994
55-59	\$387	\$813	\$578	\$935	55-59	\$430	\$903	\$643	\$1,039	55-59	\$473	\$993	\$707	\$1,142
60-64	\$477	\$906	\$638	\$1,058	60-64	\$530	\$1,007	\$709	\$1,176	60-64	\$583	\$1,108	\$780	\$1,293
65+	\$541	\$1,169	\$813	\$1,285	65+	\$601	\$1,299	\$904	\$1,428	65+	\$661	\$1,429	\$994	\$1,571
\$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	\$180	\$504	\$495	\$701	<30	\$200	\$560	\$550	\$779	<30	\$221	\$617	\$606	\$858
30-39	\$199	\$541	\$509	\$775	30-39	\$222	\$602	\$567	\$862	30-39	\$244	\$662	\$623	\$948
40-49	\$257	\$592	\$488	\$781	40-49	\$286	\$658	\$543	\$868	40-49	\$314	\$723	\$597	\$954
50-54	\$335	\$696	\$552	\$890	50-54	\$372	\$773	\$613	\$988	50-54	\$409	\$850	\$675	\$1,087
55-59	\$423	\$888	\$632	\$1,021	55-59	\$470	\$987	\$703	\$1,135	55-59	\$517	\$1,086	\$773	\$1,249
60-64	\$522	\$991	\$698	\$1,157	60-64	\$580	\$1,101	\$776	\$1,285	60-64	\$638	\$1,212	\$853	\$1,415
65+	\$592	\$1,279	\$890	\$1,406	65+	\$658	\$1,421	\$989	\$1,562	65+	\$723	\$1,563	\$1,087	\$1,718
\$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	\$197	\$551	\$541	\$767	<30	\$219	\$612	\$602	\$852	<30	\$241	\$673	\$662	\$937
30-39	\$218	\$592	\$557	\$847	30-39	\$242	\$658	\$619	\$942	30-39	\$266	\$723	\$680	\$1,035
40-49	\$281	\$647	\$534	\$854	40-49	\$312	\$718	\$593	\$948	40-49	\$343	\$790	\$652	\$1,043
50-54	\$366	\$761	\$603	\$973	50-54	\$406	\$844	\$670	\$1,079	50-54	\$447	\$929	\$737	\$1,188
55-59	\$462	\$970	\$691	\$1,116	55-59	\$514	\$1,079	\$768	\$1,241	55-59	\$565	\$1,186	\$845	\$1,364
60-64	\$570	\$1,083	\$762	\$1,264	60-64	\$633	\$1,203	\$847	\$1,404	60-64	\$697	\$1,324	\$932	\$1,546
65+	\$647	\$1,398	\$972	\$1,537	65+	\$718	\$1,552	\$1,080	\$1,706	65+	\$790	\$1,708	\$1,188	\$1,878
\$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	\$217	\$606	\$596	\$843	<30	\$241	\$673	\$662	\$936	<30	\$265	\$740	\$728	\$1,030
30-39	\$239	\$650	\$612	\$931	30-39	\$266	\$723	\$680	\$1,035	30-39	\$293	\$796	\$748	\$1,139
40-49	\$309	\$711	\$587	\$938	40-49	\$343	\$790	\$652	\$1,043	40-49	\$378	\$869	\$718	\$1,147
50-54	\$402	\$836	\$663	\$1,069	50-54	\$447	\$929	\$737	\$1,187	50-54	\$491	\$1,021	\$810	\$1,305
55-59	\$508	\$1,067	\$759	\$1,227	55-59	\$565	\$1,186	\$844	\$1,364	55-59	\$621	\$1,304	\$928	\$1,500
60-64	\$627	\$1,191	\$838	\$1,390	60-64	\$696	\$1,322	\$931	\$1,543	60-64	\$766	\$1,455	\$1,024	\$1,699
65+	\$711	\$1,536	\$1,069	\$1,689	65+	\$790	\$1,707	\$1,188	\$1,877	65+	\$869	\$1,878	\$1,306	\$2,064
\$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	\$269	\$752	\$739	\$1,046	<30	\$299	\$835	\$821	\$1,162	<30	\$329	\$919	\$904	\$1,279
30-39	\$297	\$808	\$760	\$1,157	30-39	\$330	\$897	\$844	\$1,284	30-39	\$363	\$987	\$929	\$1,413
40-49	\$384	\$883	\$729	\$1,165	40-49	\$426	\$980	\$810	\$1,294	40-49	\$469	\$1,079	\$891	\$1,424
50-54	\$499	\$1,038	\$823	\$1,327	50-54	\$555	\$1,153	\$915	\$1,474	50-54	\$610	\$1,268	\$1,006	\$1,621
55-59	\$631	\$1,325	\$943	\$1,524	55-59	\$701	\$1,472	\$1,048	\$1,693	55-59	\$771	\$1,619	\$1,153	\$1,862
60-64	\$778	\$1,478	\$1,041	\$1,725	60-64	\$865	\$1,643	\$1,157	\$1,918	60-64	\$951	\$1,807	\$1,272	\$2,109
65+	\$883	\$1,908	\$1,327	\$2,097	65+	\$981	\$2,120	\$1,475	\$2,330	65+	\$1,079	\$2,332	\$1,622	\$2,564

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

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS

EFFECTIVE 7/1/09–12/1/09

PLAN HIGHLIGHTS

**MOST POPULAR
DEDUCTIBLE PLAN**

FEATURES	\$30/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,200 PLAN W/HSA MEMBER PAYS	\$0/\$1,500 PLAN W/HSA MEMBER PAYS
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 MAXIMUM³ 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 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) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)
PRESCRIPTIONS⁷ Generic Brand-name	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)
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)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)
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) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)
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) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)
OTHER Certain durable medical equipment (DME) ⁹ Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

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

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

⁶23 months or younger

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.

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS RATE AREA 5 EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$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	\$88	\$242	\$200	\$292	<30	\$98	\$269	\$222	\$324	<30	\$108	\$296	\$244	\$357
30-39	\$104	\$279	\$210	\$327	30-39	\$116	\$310	\$234	\$363	30-39	\$128	\$341	\$258	\$399
40-49	\$141	\$288	\$221	\$366	40-49	\$157	\$320	\$245	\$407	40-49	\$172	\$352	\$269	\$447
50-54	\$188	\$391	\$258	\$433	50-54	\$209	\$434	\$286	\$481	50-54	\$230	\$478	\$315	\$529
55-59	\$234	\$487	\$303	\$534	55-59	\$260	\$541	\$337	\$593	55-59	\$286	\$595	\$371	\$652
60-64	\$300	\$600	\$371	\$664	60-64	\$333	\$667	\$412	\$738	60-64	\$366	\$733	\$453	\$811
65+	\$364	\$830	\$432	\$871	65+	\$404	\$921	\$479	\$966	65+	\$445	\$1,014	\$528	\$1,064
\$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	\$100	\$274	\$226	\$330	<30	\$111	\$304	\$251	\$366	<30	\$122	\$334	\$276	\$402
30-39	\$118	\$315	\$238	\$369	30-39	\$131	\$350	\$264	\$410	30-39	\$144	\$385	\$291	\$451
40-49	\$159	\$325	\$249	\$413	40-49	\$177	\$361	\$277	\$459	40-49	\$195	\$398	\$305	\$506
50-54	\$213	\$442	\$292	\$489	50-54	\$237	\$492	\$324	\$545	50-54	\$260	\$540	\$356	\$598
55-59	\$264	\$549	\$342	\$602	55-59	\$294	\$611	\$381	\$670	55-59	\$323	\$672	\$419	\$737
60-64	\$339	\$678	\$419	\$750	60-64	\$377	\$754	\$466	\$834	60-64	\$414	\$829	\$512	\$917
65+	\$411	\$937	\$488	\$983	65+	\$457	\$1,042	\$542	\$1,093	65+	\$502	\$1,145	\$596	\$1,201
\$0/\$2,200 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	\$120	\$329	\$272	\$396	<30	\$133	\$365	\$302	\$440	<30	\$147	\$402	\$332	\$484
30-39	\$142	\$379	\$286	\$444	30-39	\$158	\$421	\$318	\$493	30-39	\$173	\$463	\$350	\$542
40-49	\$192	\$392	\$300	\$498	40-49	\$213	\$435	\$333	\$553	40-49	\$234	\$478	\$366	\$607
50-54	\$256	\$532	\$351	\$589	50-54	\$285	\$591	\$390	\$654	50-54	\$313	\$650	\$429	\$720
55-59	\$318	\$661	\$412	\$725	55-59	\$353	\$734	\$458	\$805	55-59	\$389	\$808	\$504	\$886
60-64	\$407	\$815	\$503	\$902	60-64	\$453	\$906	\$560	\$1,002	60-64	\$498	\$997	\$616	\$1,103
65+	\$494	\$1,127	\$586	\$1,182	65+	\$549	\$1,252	\$652	\$1,313	65+	\$604	\$1,377	\$717	\$1,445
\$0/\$1,500 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	\$129	\$354	\$293	\$427	<30	\$144	\$394	\$326	\$475	<30	\$158	\$433	\$358	\$522
30-39	\$153	\$409	\$309	\$479	30-39	\$170	\$454	\$343	\$532	30-39	\$187	\$500	\$377	\$585
40-49	\$207	\$422	\$324	\$536	40-49	\$230	\$469	\$360	\$596	40-49	\$253	\$516	\$396	\$656
50-54	\$276	\$573	\$378	\$634	50-54	\$307	\$637	\$420	\$705	50-54	\$338	\$701	\$463	\$776
55-59	\$343	\$713	\$445	\$782	55-59	\$381	\$792	\$494	\$868	55-59	\$419	\$871	\$543	\$955
60-64	\$439	\$879	\$543	\$973	60-64	\$488	\$977	\$603	\$1,081	60-64	\$537	\$1,075	\$664	\$1,189
65+	\$533	\$1,215	\$633	\$1,275	65+	\$592	\$1,350	\$703	\$1,416	65+	\$652	\$1,486	\$774	\$1,559

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 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)
PRESCRIPTIONS⁶		
Generic ³	(up to a 100-day supply) \$10	(up to a 100-day supply) \$10
Brand-name	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
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 SERVICES⁷		
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.

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

⁵23 months or younger

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.

KAISER PERMANENTE DEDUCTIBLE HMO PLANS RATE AREA 5

EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$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	\$122	\$334	\$276	\$402	<30	\$135	\$370	\$306	\$446	<30	\$149	\$408	\$337	\$492
30–39	\$144	\$385	\$291	\$451	30–39	\$160	\$428	\$323	\$501	30–39	\$176	\$470	\$355	\$550
40–49	\$195	\$398	\$305	\$505	40–49	\$216	\$441	\$338	\$560	40–49	\$238	\$486	\$372	\$617
50–54	\$260	\$540	\$356	\$598	50–54	\$289	\$600	\$396	\$664	50–54	\$318	\$660	\$435	\$731
55–59	\$323	\$671	\$419	\$736	55–59	\$359	\$746	\$465	\$818	55–59	\$395	\$821	\$512	\$900
60–64	\$414	\$828	\$512	\$916	60–64	\$460	\$920	\$569	\$1,018	60–64	\$506	\$1,012	\$625	\$1,120
65+	\$502	\$1,144	\$596	\$1,200	65+	\$558	\$1,272	\$662	\$1,334	65+	\$613	\$1,398	\$728	\$1,467
\$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	\$140	\$384	\$318	\$463	<30	\$156	\$427	\$353	\$515	<30	\$172	\$471	\$389	\$567
30–39	\$166	\$444	\$335	\$520	30–39	\$184	\$492	\$372	\$576	30–39	\$203	\$542	\$410	\$635
40–49	\$224	\$458	\$351	\$582	40–49	\$249	\$509	\$390	\$647	40–49	\$274	\$559	\$429	\$710
50–54	\$300	\$623	\$411	\$690	50–54	\$333	\$691	\$456	\$765	50–54	\$366	\$760	\$501	\$841
55–59	\$372	\$774	\$482	\$848	55–59	\$413	\$859	\$536	\$942	55–59	\$455	\$946	\$590	\$1,037
60–64	\$477	\$955	\$590	\$1,057	60–64	\$530	\$1,061	\$655	\$1,174	60–64	\$583	\$1,167	\$721	\$1,291
65+	\$578	\$1,318	\$686	\$1,383	65+	\$643	\$1,466	\$763	\$1,538	65+	\$707	\$1,612	\$839	\$1,691

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 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 DEDUCTIBLE¹ 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)
PRESCRIPTIONS⁶		
Generic ³	(up to a 100-day supply) \$10	(up to a 100-day supply) \$10
Brand-name	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
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 SERVICES⁷		
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.

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

⁵23 months or younger

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.

KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA RATE AREA 5

EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF 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 HRA²														
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	\$112	\$307	\$254	\$370	<30	\$125	\$342	\$282	\$412	<30	\$137	\$375	\$310	\$452
30–39	\$133	\$355	\$268	\$415	30–39	\$147	\$393	\$297	\$460	30–39	\$162	\$433	\$327	\$507
40–49	\$179	\$366	\$280	\$465	40–49	\$199	\$406	\$311	\$516	40–49	\$219	\$447	\$343	\$568
50–54	\$239	\$497	\$327	\$550	50–54	\$266	\$552	\$364	\$611	50–54	\$292	\$607	\$400	\$672
55–59	\$297	\$618	\$385	\$677	55–59	\$330	\$686	\$428	\$752	55–59	\$363	\$755	\$471	\$828
60–64	\$381	\$762	\$471	\$843	60–64	\$423	\$847	\$523	\$937	60–64	\$465	\$931	\$575	\$1,030
65+	\$462	\$1,053	\$548	\$1,105	65+	\$513	\$1,170	\$609	\$1,227	65+	\$564	\$1,287	\$669	\$1,350
\$30/\$1,500 PLAN WITH HRA²														
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	\$125	\$343	\$283	\$413	<30	\$139	\$381	\$315	\$459	<30	\$153	\$419	\$347	\$505
30–39	\$148	\$396	\$299	\$464	30–39	\$165	\$440	\$333	\$515	30–39	\$181	\$484	\$365	\$567
40–49	\$200	\$408	\$313	\$519	40–49	\$222	\$454	\$348	\$577	40–49	\$245	\$500	\$383	\$635
50–54	\$267	\$555	\$366	\$614	50–54	\$297	\$617	\$407	\$683	50–54	\$327	\$679	\$448	\$752
55–59	\$332	\$690	\$430	\$756	55–59	\$369	\$767	\$478	\$841	55–59	\$406	\$844	\$526	\$925
60–64	\$425	\$851	\$525	\$942	60–64	\$473	\$946	\$585	\$1,047	60–64	\$520	\$1,041	\$643	\$1,152
65+	\$516	\$1,177	\$612	\$1,235	65+	\$573	\$1,307	\$680	\$1,371	65+	\$631	\$1,438	\$749	\$1,509

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.

¹Risk adjustment factor

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

KAISER PERMANENTE \$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 7/1/09–12/1/09

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
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 SERVICES¹⁴			
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 5

EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹⁹ .90					6 to 15 enrolling employees RAF ¹⁹ 1.00					5 or fewer enrolling employees RAF ¹⁹ 1.10				
\$35 POS PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$320	\$906	\$825	\$1,179	<30	\$355	\$1,006	\$916	\$1,310	<30	\$391	\$1,107	\$1,008	\$1,441
30–39	\$367	\$1,006	\$859	\$1,322	30–39	\$408	\$1,118	\$955	\$1,469	30–39	\$448	\$1,229	\$1,050	\$1,615
40–49	\$479	\$1,066	\$840	\$1,372	40–49	\$533	\$1,185	\$934	\$1,525	40–49	\$586	\$1,303	\$1,027	\$1,676
50–54	\$632	\$1,317	\$985	\$1,604	50–54	\$702	\$1,463	\$1,095	\$1,782	50–54	\$772	\$1,610	\$1,204	\$1,961
55–59	\$791	\$1,661	\$1,139	\$1,892	55–59	\$879	\$1,846	\$1,266	\$2,103	55–59	\$967	\$2,031	\$1,393	\$2,313
60–64	\$995	\$1,928	\$1,283	\$2,183	60–64	\$1,106	\$2,142	\$1,426	\$2,425	60–64	\$1,216	\$2,356	\$1,568	\$2,668
65+	\$1,204	\$2,654	\$1,599	\$2,771	65+	\$1,337	\$2,948	\$1,776	\$3,078	65+	\$1,471	\$3,243	\$1,954	\$3,386

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.

- ¹Deductible 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.
- 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*).
- 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.
- ⁴Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.
- ⁵Scheduled prenatal visits and the first postpartum visit
- ⁶Well-child care is covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger.
- ⁷Well-child care (ages 0 to 18) is exempt from deductibles from PHCS network providers and includes immunizations.
- ⁸In 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.
- ⁹All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.
- ¹⁰A 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.
- ¹¹Participating 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.
- ¹²Care in a skilled nursing facility is limited to 100 days per benefit period.
- ¹³Kaiser 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.
- ¹⁴Visit 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*.
- ¹⁵Please 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.
- ¹⁶Durable 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.
- ¹⁷Home 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.
- ¹⁸Hospice care is limited to a 180-day lifetime benefit maximum for services from PHCS network and nonparticipating providers combined.
- ¹⁹Risk adjustment factor

HMO exclusions and limitations

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

FEATURES	PHCS network (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS
MEDICAL 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 ⁸ 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% ²⁰ 50% 50% 50% 50% 50% 50% Not covered Not covered 50% 50%
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service ⁹ Nonemergency urgent care	\$100 copay, then 50% (copay waived if admitted) 50% 50% 30%	\$100 copay, then 50% (copay waived if admitted) 50% 50% 50%
PRESCRIPTIONS¹⁰ Generic drugs Brand-name drugs Self-administered injectable medications ¹² Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹¹ \$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 ¹³ All other covered mental illness ¹⁴ Outpatient visits Severe mental illness and serious emotional disturbances of a child ¹³ All other covered mental illness ¹⁵	30% 30% \$40 copay 30%	50% ⁴ 50% 50% 50%
ALCOHOL AND CHEMICAL DEPENDENCY¹⁶ Inpatient hospitalization ¹⁴ Outpatient visits ¹⁵	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 ¹⁷ Durable medical equipment (DME) ¹⁸ Prosthetics, orthotics, and special footwear Diabetic equipment and supplies ¹⁹	30% 20% 30% 30% 30% 30% 30%	50% 20% Not covered 50% 50% 50% 30%

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

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

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees
RAF²¹ .90

6 to 15 enrolling employees
RAF²¹ 1.00

5 or fewer enrolling employees
RAF²¹ 1.10

\$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	\$272	\$793	\$589	\$890	<30	\$303	\$882	\$656	\$990	<30	\$333	\$970	\$721	\$1,089
30–39	\$336	\$937	\$653	\$1,032	30–39	\$373	\$1,041	\$726	\$1,147	30–39	\$410	\$1,145	\$798	\$1,262
40–49	\$449	\$990	\$688	\$1,144	40–49	\$499	\$1,100	\$765	\$1,271	40–49	\$549	\$1,211	\$841	\$1,399
50–54	\$605	\$1,268	\$792	\$1,353	50–54	\$672	\$1,409	\$880	\$1,504	50–54	\$739	\$1,550	\$968	\$1,654
55–59	\$745	\$1,565	\$930	\$1,647	55–59	\$828	\$1,740	\$1,034	\$1,831	55–59	\$911	\$1,914	\$1,138	\$2,014
60–64	\$971	\$1,942	\$1,156	\$2,022	60–64	\$1,079	\$2,157	\$1,284	\$2,246	60–64	\$1,187	\$2,373	\$1,413	\$2,471
65+	\$1,208	\$2,817	\$1,391	\$2,892	65+	\$1,342	\$3,130	\$1,546	\$3,213	65+	\$1,476	\$3,442	\$1,700	\$3,533

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.

***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.

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

⁹The 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.

¹⁰Member 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.

¹¹MedImpact 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.

¹²Self-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.

¹³Severe 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.

¹⁴Benefits 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.

¹⁵Benefits 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.

¹⁶In 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.

¹⁷Benefits 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.

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

¹⁹Diabetic 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.

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

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 7/1/09–12/1/09

FEATURES	PHCS network (PPO) ¹	Nonparticipating providers (out-of-network) ¹
	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE² 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 INSURED⁴	\$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%
PRESCRIPTIONS¹²	MedImpact pharmacy¹³	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 DEPENDENCY¹⁸		
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.

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

EFFECTIVE 7/1/09–12/1/09

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ²⁴ .90					6 to 15 enrolling employees RAF ²⁴ 1.00					5 or fewer enrolling employees RAF ²⁴ 1.10				
\$40/\$1,000 PPO INSURANCE PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$294	\$857	\$637	\$962	<30	\$327	\$953	\$708	\$1,070	<30	\$360	\$1,049	\$779	\$1,177
30–39	\$363	\$1,013	\$706	\$1,116	30–39	\$403	\$1,125	\$784	\$1,240	30–39	\$444	\$1,239	\$863	\$1,365
40–49	\$486	\$1,071	\$744	\$1,237	40–49	\$540	\$1,190	\$827	\$1,375	40–49	\$594	\$1,309	\$910	\$1,512
50–54	\$654	\$1,371	\$856	\$1,463	50–54	\$726	\$1,523	\$951	\$1,625	50–54	\$799	\$1,675	\$1,046	\$1,788
55–59	\$806	\$1,693	\$1,006	\$1,781	55–59	\$895	\$1,880	\$1,118	\$1,978	55–59	\$985	\$2,069	\$1,230	\$2,177
60–64	\$1,050	\$2,099	\$1,250	\$2,185	60–64	\$1,166	\$2,332	\$1,388	\$2,428	60–64	\$1,283	\$2,565	\$1,527	\$2,670
65+	\$1,306	\$3,045	\$1,504	\$3,126	65+	\$1,451	\$3,384	\$1,671	\$3,474	65+	\$1,596	\$3,722	\$1,838	\$3,821

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.

- ¹Payments 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.
- ²Medical 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.
- ³Covered 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.
- ⁴Maximum benefit while insured is combined for services provided by PHCS network and nonparticipating providers.
- ⁵Kaiser 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.
- ⁶Brand-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.
- ⁷This service is not subject to a deductible.
- ⁸Routine adult physical exams are limited to one exam every 12 months and \$400 per calendar year.
- ⁹Well-child preventive care is exempt from deductibles and includes immunizations.
- 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 a sickness.
- ²¹DME is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS network and nonparticipating providers.
- 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.
- ²³Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.
- ²⁴Risk 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*.

KAISER PERMANENTE RATE AREA 5

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

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

90001-84	90723	91199	91976-80
90086-89	90731-34	91201-10	91987
90091	90744-49	91214	92007-11
90093-96	90755	91221-22	92013-14
90101	90801-10	91224-26	92018-27
90103	90813-15	91501-08	92029-30
90189	90822	91510	92033
90201-02	90831-35	91521-23	92037-40
90209-13	90840	91702	92046
90220-24	90842	91706	92049
90230-32	90844	91714-16	92051-52
90239-42	90846-48	91722-24	92054-58
90245	90853	91731-35	92064-65
90247-51	90895	91740-41	92067-69
90254-55	91001	91744-50	92071-72
90260-67	91003	91754-56	92074-75
90270	91006-12	91765	92078-79
90272	91016-17	91770-73	92081-85
90274-75	91020-21	91775-76	92090-93
90277-78	91023-25	91778	92096
90280	91030-31	91780	92101-24
90290-96	91040-43	91788-93	92126-32
90301-12	91046	91795	92134-40
90401-11	91066	91801-04	92142-43
90501-10	91077	91896	92145
90601-10	91101-10	91901-03	92147
90637-40	91114-18	91908-17	92149-50
90650-52	91121	91921	92152-55
90660-62	91123-26	91931-33	92158-79
90670-71	91129	91935	92182
90701-03	91182	91941-47	92184
90706-07	91184-85	91950-51	92186-87
90710-17	91188-89	91962-63	92190-99

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