

PLAN HIGHLIGHTS AND RATES

Effective July to December 2009

2009 SMALL BUSINESS RATE AREA 6

- 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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Deductible plans with lower monthly premiums and optional employee-owned savings accounts

Deductible HMO plans

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

Deductible HMO plans with health reimbursement arrangement (HRA)

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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 6

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	\$156	\$436	\$429	\$607	<30	\$174	\$486	\$477	\$676	<30	\$191	\$534	\$525	\$743
30–39	\$173	\$470	\$442	\$672	30–39	\$192	\$522	\$491	\$747	30–39	\$211	\$573	\$540	\$820
40–49	\$223	\$513	\$424	\$677	40–49	\$248	\$570	\$471	\$752	40–49	\$272	\$626	\$517	\$826
50–54	\$290	\$603	\$478	\$771	50–54	\$322	\$670	\$531	\$856	50–54	\$354	\$736	\$584	\$941
55–59	\$367	\$770	\$548	\$886	55–59	\$407	\$855	\$609	\$983	55–59	\$448	\$941	\$670	\$1,082
60–64	\$452	\$859	\$605	\$1,003	60–64	\$502	\$954	\$671	\$1,114	60–64	\$553	\$1,050	\$739	\$1,226
65+	\$513	\$1,108	\$771	\$1,218	65+	\$570	\$1,231	\$857	\$1,353	65+	\$627	\$1,355	\$942	\$1,489
\$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	\$171	\$478	\$470	\$665	<30	\$190	\$531	\$522	\$739	<30	\$209	\$584	\$574	\$813
30–39	\$189	\$513	\$483	\$734	30–39	\$210	\$570	\$537	\$816	30–39	\$231	\$627	\$590	\$898
40–49	\$244	\$561	\$463	\$740	40–49	\$271	\$623	\$515	\$822	40–49	\$298	\$685	\$566	\$904
50–54	\$317	\$659	\$523	\$842	50–54	\$352	\$732	\$581	\$936	50–54	\$388	\$806	\$640	\$1,030
55–59	\$401	\$842	\$599	\$968	55–59	\$445	\$935	\$665	\$1,075	55–59	\$490	\$1,029	\$732	\$1,183
60–64	\$494	\$939	\$661	\$1,096	60–64	\$549	\$1,043	\$734	\$1,218	60–64	\$604	\$1,147	\$808	\$1,339
65+	\$561	\$1,212	\$843	\$1,332	65+	\$623	\$1,346	\$937	\$1,480	65+	\$685	\$1,481	\$1,030	\$1,628
\$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	\$187	\$522	\$513	\$726	<30	\$208	\$580	\$571	\$807	<30	\$228	\$637	\$627	\$887
30–39	\$206	\$560	\$527	\$802	30–39	\$229	\$623	\$586	\$892	30–39	\$252	\$685	\$645	\$981
40–49	\$266	\$612	\$506	\$808	40–49	\$296	\$681	\$562	\$899	40–49	\$325	\$748	\$618	\$987
50–54	\$347	\$721	\$572	\$921	50–54	\$385	\$800	\$635	\$1,023	50–54	\$424	\$881	\$699	\$1,126
55–59	\$438	\$920	\$655	\$1,058	55–59	\$487	\$1,022	\$728	\$1,175	55–59	\$535	\$1,124	\$800	\$1,293
60–64	\$540	\$1,026	\$722	\$1,198	60–64	\$600	\$1,140	\$802	\$1,331	60–64	\$660	\$1,254	\$883	\$1,464
65+	\$613	\$1,324	\$921	\$1,455	65+	\$681	\$1,471	\$1,024	\$1,617	65+	\$749	\$1,618	\$1,126	\$1,779
\$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	\$205	\$573	\$564	\$798	<30	\$228	\$637	\$627	\$887	<30	\$251	\$701	\$689	\$976
30–39	\$227	\$617	\$580	\$883	30–39	\$252	\$685	\$644	\$980	30–39	\$277	\$753	\$708	\$1,078
40–49	\$293	\$674	\$556	\$889	40–49	\$325	\$748	\$618	\$987	40–49	\$358	\$823	\$680	\$1,086
50–54	\$381	\$792	\$628	\$1,012	50–54	\$423	\$880	\$698	\$1,125	50–54	\$466	\$968	\$768	\$1,237
55–59	\$481	\$1,011	\$719	\$1,163	55–59	\$535	\$1,123	\$800	\$1,292	55–59	\$588	\$1,235	\$879	\$1,421
60–64	\$594	\$1,128	\$794	\$1,317	60–64	\$660	\$1,253	\$883	\$1,463	60–64	\$726	\$1,379	\$971	\$1,610
65+	\$673	\$1,455	\$1,012	\$1,600	65+	\$748	\$1,617	\$1,125	\$1,778	65+	\$823	\$1,779	\$1,237	\$1,956
\$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	\$255	\$712	\$700	\$991	<30	\$283	\$791	\$778	\$1,101	<30	\$312	\$871	\$856	\$1,212
30–39	\$282	\$766	\$720	\$1,096	30–39	\$313	\$850	\$800	\$1,217	30–39	\$344	\$935	\$880	\$1,339
40–49	\$363	\$836	\$690	\$1,103	40–49	\$404	\$929	\$767	\$1,226	40–49	\$444	\$1,022	\$844	\$1,349
50–54	\$473	\$983	\$780	\$1,257	50–54	\$526	\$1,093	\$867	\$1,397	50–54	\$578	\$1,202	\$953	\$1,536
55–59	\$598	\$1,256	\$894	\$1,444	55–59	\$664	\$1,395	\$993	\$1,604	55–59	\$731	\$1,535	\$1,093	\$1,765
60–64	\$737	\$1,400	\$986	\$1,634	60–64	\$819	\$1,556	\$1,095	\$1,816	60–64	\$901	\$1,712	\$1,205	\$1,998
65+	\$836	\$1,807	\$1,257	\$1,986	65+	\$929	\$2,008	\$1,397	\$2,207	65+	\$1,022	\$2,209	\$1,536	\$2,428

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

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 6 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	\$84	\$229	\$190	\$276	<30	\$93	\$255	\$210	\$307	<30	\$102	\$280	\$231	\$337
30-39	\$99	\$264	\$200	\$309	30-39	\$110	\$294	\$222	\$344	30-39	\$121	\$323	\$244	\$378
40-49	\$134	\$273	\$209	\$347	40-49	\$149	\$304	\$233	\$386	40-49	\$163	\$333	\$255	\$423
50-54	\$179	\$371	\$245	\$411	50-54	\$198	\$411	\$271	\$455	50-54	\$218	\$453	\$299	\$501
55-59	\$222	\$461	\$288	\$505	55-59	\$246	\$512	\$319	\$561	55-59	\$271	\$563	\$351	\$617
60-64	\$284	\$568	\$351	\$629	60-64	\$316	\$632	\$391	\$699	60-64	\$347	\$695	\$429	\$769
65+	\$345	\$786	\$409	\$825	65+	\$383	\$873	\$455	\$916	65+	\$421	\$960	\$500	\$1,007
\$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	\$95	\$259	\$215	\$312	<30	\$105	\$288	\$238	\$347	<30	\$116	\$317	\$262	\$382
30-39	\$112	\$299	\$226	\$350	30-39	\$124	\$332	\$250	\$389	30-39	\$137	\$365	\$276	\$427
40-49	\$151	\$308	\$236	\$391	40-49	\$168	\$343	\$263	\$436	40-49	\$185	\$377	\$289	\$479
50-54	\$202	\$419	\$277	\$464	50-54	\$224	\$465	\$307	\$515	50-54	\$247	\$512	\$338	\$567
55-59	\$251	\$521	\$325	\$571	55-59	\$278	\$578	\$361	\$634	55-59	\$306	\$636	\$397	\$697
60-64	\$321	\$642	\$397	\$710	60-64	\$357	\$714	\$441	\$790	60-64	\$392	\$785	\$485	\$869
65+	\$389	\$887	\$462	\$931	65+	\$433	\$987	\$514	\$1,035	65+	\$476	\$1,085	\$565	\$1,138
\$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	\$114	\$312	\$258	\$376	<30	\$126	\$346	\$286	\$417	<30	\$139	\$381	\$315	\$459
30-39	\$134	\$359	\$271	\$420	30-39	\$149	\$399	\$301	\$467	30-39	\$164	\$439	\$331	\$514
40-49	\$182	\$371	\$284	\$471	40-49	\$202	\$412	\$316	\$523	40-49	\$222	\$453	\$347	\$576
50-54	\$243	\$504	\$333	\$558	50-54	\$270	\$560	\$370	\$620	50-54	\$296	\$615	\$406	\$681
55-59	\$301	\$626	\$390	\$686	55-59	\$335	\$696	\$434	\$763	55-59	\$368	\$765	\$477	\$839
60-64	\$386	\$772	\$477	\$854	60-64	\$429	\$858	\$530	\$949	60-64	\$472	\$944	\$583	\$1,045
65+	\$468	\$1,067	\$555	\$1,119	65+	\$520	\$1,186	\$617	\$1,244	65+	\$572	\$1,304	\$679	\$1,368
\$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	\$123	\$336	\$278	\$405	<30	\$136	\$373	\$308	\$449	<30	\$150	\$411	\$339	\$495
30-39	\$145	\$387	\$293	\$453	30-39	\$161	\$430	\$325	\$503	30-39	\$177	\$473	\$357	\$554
40-49	\$196	\$400	\$307	\$508	40-49	\$218	\$445	\$341	\$565	40-49	\$239	\$488	\$374	\$620
50-54	\$262	\$544	\$359	\$602	50-54	\$291	\$604	\$398	\$669	50-54	\$320	\$664	\$438	\$735
55-59	\$325	\$676	\$421	\$741	55-59	\$361	\$751	\$468	\$823	55-59	\$397	\$826	\$515	\$905
60-64	\$416	\$833	\$514	\$922	60-64	\$463	\$926	\$572	\$1,025	60-64	\$509	\$1,019	\$629	\$1,127
65+	\$505	\$1,151	\$599	\$1,207	65+	\$561	\$1,279	\$666	\$1,342	65+	\$617	\$1,407	\$732	\$1,476

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 6

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	\$115	\$316	\$261	\$381	<30	\$128	\$351	\$290	\$423	<30	\$141	\$386	\$319	\$465
30–39	\$136	\$364	\$275	\$426	30–39	\$152	\$405	\$306	\$474	30–39	\$167	\$446	\$337	\$522
40–49	\$184	\$376	\$288	\$478	40–49	\$205	\$418	\$321	\$531	40–49	\$225	\$460	\$352	\$584
50–54	\$246	\$511	\$337	\$566	50–54	\$274	\$569	\$375	\$630	50–54	\$301	\$625	\$412	\$692
55–59	\$306	\$636	\$397	\$697	55–59	\$340	\$707	\$441	\$775	55–59	\$374	\$777	\$485	\$852
60–64	\$392	\$784	\$485	\$868	60–64	\$435	\$871	\$538	\$964	60–64	\$479	\$959	\$592	\$1,061
65+	\$475	\$1,084	\$564	\$1,137	65+	\$528	\$1,204	\$627	\$1,263	65+	\$581	\$1,325	\$690	\$1,390
\$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	\$133	\$364	\$301	\$439	<30	\$148	\$405	\$335	\$488	<30	\$163	\$446	\$369	\$537
30–39	\$157	\$420	\$317	\$492	30–39	\$175	\$467	\$353	\$547	30–39	\$192	\$513	\$388	\$601
40–49	\$213	\$434	\$333	\$551	40–49	\$236	\$482	\$369	\$612	40–49	\$260	\$530	\$407	\$673
50–54	\$284	\$590	\$389	\$653	50–54	\$315	\$655	\$432	\$725	50–54	\$347	\$720	\$475	\$797
55–59	\$353	\$734	\$458	\$804	55–59	\$392	\$815	\$508	\$893	55–59	\$431	\$896	\$559	\$982
60–64	\$452	\$904	\$559	\$1,000	60–64	\$502	\$1,005	\$621	\$1,112	60–64	\$552	\$1,105	\$682	\$1,223
65+	\$548	\$1,249	\$650	\$1,310	65+	\$609	\$1,388	\$723	\$1,456	65+	\$670	\$1,527	\$795	\$1,602

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 6

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	\$106	\$291	\$240	\$351	<30	\$118	\$323	\$267	\$389	<30	\$130	\$356	\$294	\$429
30–39	\$126	\$336	\$254	\$393	30–39	\$139	\$372	\$281	\$436	30–39	\$153	\$410	\$309	\$480
40–49	\$170	\$347	\$266	\$441	40–49	\$189	\$385	\$295	\$489	40–49	\$207	\$423	\$324	\$538
50–54	\$227	\$471	\$311	\$521	50–54	\$252	\$523	\$345	\$579	50–54	\$277	\$575	\$379	\$637
55–59	\$281	\$585	\$364	\$641	55–59	\$313	\$651	\$406	\$714	55–59	\$344	\$715	\$446	\$784
60–64	\$361	\$722	\$446	\$799	60–64	\$401	\$802	\$496	\$887	60–64	\$441	\$882	\$545	\$976
65+	\$438	\$998	\$520	\$1,047	65+	\$486	\$1,108	\$577	\$1,162	65+	\$535	\$1,220	\$635	\$1,280
\$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	\$119	\$325	\$269	\$392	<30	\$132	\$361	\$299	\$435	<30	\$145	\$397	\$328	\$478
30–39	\$140	\$375	\$283	\$439	30–39	\$156	\$417	\$315	\$488	30–39	\$171	\$458	\$346	\$536
40–49	\$190	\$387	\$297	\$492	40–49	\$211	\$430	\$330	\$546	40–49	\$232	\$473	\$363	\$601
50–54	\$253	\$526	\$347	\$582	50–54	\$281	\$584	\$385	\$647	50–54	\$310	\$643	\$424	\$712
55–59	\$315	\$655	\$408	\$718	55–59	\$349	\$726	\$453	\$796	55–59	\$384	\$799	\$498	\$876
60–64	\$403	\$807	\$498	\$893	60–64	\$448	\$896	\$554	\$991	60–64	\$493	\$986	\$609	\$1,091
65+	\$489	\$1,115	\$580	\$1,170	65+	\$543	\$1,238	\$644	\$1,299	65+	\$598	\$1,363	\$710	\$1,430

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 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 6

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	\$303	\$858	\$781	\$1,117	<30	\$337	\$954	\$868	\$1,242	<30	\$370	\$1,049	\$954	\$1,365
30–39	\$348	\$954	\$814	\$1,253	30–39	\$386	\$1,059	\$904	\$1,391	30–39	\$425	\$1,165	\$995	\$1,531
40–49	\$454	\$1,010	\$796	\$1,299	40–49	\$505	\$1,122	\$885	\$1,444	40–49	\$555	\$1,234	\$973	\$1,588
50–54	\$598	\$1,247	\$933	\$1,519	50–54	\$665	\$1,386	\$1,037	\$1,688	50–54	\$731	\$1,524	\$1,140	\$1,856
55–59	\$749	\$1,573	\$1,079	\$1,792	55–59	\$833	\$1,749	\$1,200	\$1,992	55–59	\$916	\$1,924	\$1,320	\$2,192
60–64	\$943	\$1,826	\$1,215	\$2,068	60–64	\$1,048	\$2,030	\$1,351	\$2,298	60–64	\$1,152	\$2,232	\$1,485	\$2,527
65+	\$1,140	\$2,514	\$1,514	\$2,625	65+	\$1,267	\$2,793	\$1,683	\$2,916	65+	\$1,394	\$3,073	\$1,851	\$3,208

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% ⁴ 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 6

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 6**

Below is a listing of all ZIP codes within Rate Area 6.

Orange County is entirely within
Rate Area 6.

90620-24	92799
90630-33	92801-09
90680	92811-12
90720-21	92814-17
90740	92821-23
90742-43	92825
92602-07	92831-38
92609-10	92840-46
92612	92850
92614-20	92856-57
92623-30	92859
92637	92861-71
92646-63	92885-87
92672-79	92899
92683-85	
92688	
92690-94	
92697-98	
92701-08	
92711-12	
92728	
92735	
92780-82	

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