

Notice of Correction – effective July 1, 2010, through December 31, 2010

This brochure was printed with errors in the benefits for Mental Health Care inpatient services. These errors are related to the cost-sharing amounts in our \$40/\$2,500 PPO with HSA Option and \$40/\$1000 PPO plans.

Changes Affecting Copayments for the PPO Plans

\$40/\$2,500 PPO Plan with HSA Option		
Benefits	Error	Correction
Mental Health – Inpatient hospitalization PHCS network	\$40 copay	30%

\$40/\$1,000 PPO Plan		
Benefits	Error	Correction
Mental Health – Inpatient hospitalization PHCS network	\$40 copay	30%

PLAN HIGHLIGHTS AND RATES

Effective July to December 2010

2010 SMALL BUSINESS RATE AREA 1

WELCOME TO KAISER PERMANENTE

On these pages, you'll find an overview of available plan benefits for small businesses. A full listing of all Kaiser Permanente plans and benefits can be found in your 2010 Kaiser Foundation Health Plan *Evidence of Coverage* and your Kaiser Permanente Insurance Company *Certificate of Insurance*.

Why not give them a choice?

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

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

It's a business advantage, too.

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

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

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Lower monthly premiums, and preventive care and doctor visits are not subject to the deductible
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The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan and the out-of-network portion of the POS plan.

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 7/1/10–12/1/10

FEATURES	MOST POPULAR COPAYMENT PLAN				
	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	\$0	\$0	\$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM¹ Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,000/\$6,000	\$2,500/\$5,000	\$2,500/\$5,000	\$1,500/\$3,000
IN THE MEDICAL OFFICE					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/Prenatal care ²	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits ³	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$0
Infertility services	Not covered	Not covered	Not covered	50%	50%
Occupational, physical, and speech therapy	\$50	\$30	\$20	\$15	\$5
Most labs and imaging	\$10	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50	\$50
Outpatient surgery	\$250 per procedure	\$200 per procedure	\$150 per procedure	\$100 per procedure	\$5 per procedure
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
PRESCRIPTIONS⁴	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)
Generic ⁵	\$10	\$10	\$10	\$10	\$5
Brand-name	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 ⁵	\$25 ⁵	\$15 ⁵
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
Skilled nursing facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
MENTAL HEALTH SERVICES					
In the medical office	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital	\$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 ⁶	Not covered ⁶	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered ⁷	Not covered ⁷	Not covered ⁷	\$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

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

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

²Scheduled prenatal visits and the first postpartum visit

³Well-child visits through age 23 months

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

⁵This service is not subject to a deductible.

⁶Please refer to the *Evidence of Coverage* for more information; most DME is not covered.

⁷Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

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

KAISER PERMANENTE COPAYMENT PLANS RATE AREA 1

EFFECTIVE 7/1/10-12/1/10

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$50 PLAN					\$50 PLAN					\$50 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$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
\$30 PLAN					\$30 PLAN					\$30 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$226	\$631	\$620	\$878	<30	\$251	\$701	\$689	\$975	<30	\$276	\$771	\$758	\$1,073
30-39	\$249	\$677	\$637	\$969	30-39	\$277	\$753	\$708	\$1,078	30-39	\$305	\$828	\$779	\$1,185
40-49	\$322	\$741	\$612	\$978	40-49	\$358	\$823	\$680	\$1,086	40-49	\$393	\$905	\$747	\$1,194
50-54	\$419	\$871	\$691	\$1,113	50-54	\$465	\$967	\$767	\$1,236	50-54	\$512	\$1,064	\$844	\$1,360
55-59	\$529	\$1,111	\$791	\$1,278	55-59	\$588	\$1,235	\$879	\$1,420	55-59	\$647	\$1,359	\$967	\$1,563
60-64	\$653	\$1,240	\$873	\$1,448	60-64	\$725	\$1,377	\$970	\$1,608	60-64	\$798	\$1,516	\$1,067	\$1,770
65+	\$740	\$1,600	\$1,113	\$1,759	65+	\$823	\$1,778	\$1,237	\$1,955	65+	\$905	\$1,956	\$1,360	\$2,150
\$20 PLAN					\$20 PLAN					\$20 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$249	\$695	\$684	\$967	<30	\$277	\$773	\$760	\$1,076	<30	\$304	\$850	\$836	\$1,183
30-39	\$275	\$747	\$703	\$1,069	30-39	\$306	\$831	\$782	\$1,189	30-39	\$336	\$913	\$859	\$1,307
40-49	\$355	\$817	\$674	\$1,078	40-49	\$394	\$907	\$749	\$1,197	40-49	\$434	\$998	\$824	\$1,317
50-54	\$462	\$960	\$762	\$1,227	50-54	\$513	\$1,067	\$846	\$1,364	50-54	\$565	\$1,174	\$931	\$1,500
55-59	\$584	\$1,226	\$873	\$1,410	55-59	\$649	\$1,362	\$970	\$1,566	55-59	\$713	\$1,498	\$1,066	\$1,723
60-64	\$720	\$1,368	\$963	\$1,597	60-64	\$800	\$1,520	\$1,070	\$1,774	60-64	\$880	\$1,671	\$1,177	\$1,951
65+	\$816	\$1,764	\$1,227	\$1,939	65+	\$907	\$1,960	\$1,364	\$2,155	65+	\$998	\$2,157	\$1,500	\$2,371
\$15 PLAN					\$15 PLAN					\$15 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$266	\$744	\$731	\$1,035	<30	\$296	\$827	\$813	\$1,151	<30	\$325	\$909	\$894	\$1,265
30-39	\$294	\$799	\$752	\$1,144	30-39	\$327	\$888	\$836	\$1,271	30-39	\$360	\$977	\$920	\$1,398
40-49	\$380	\$874	\$722	\$1,153	40-49	\$422	\$971	\$802	\$1,281	40-49	\$464	\$1,067	\$882	\$1,408
50-54	\$494	\$1,027	\$815	\$1,313	50-54	\$549	\$1,141	\$905	\$1,458	50-54	\$604	\$1,255	\$996	\$1,604
55-59	\$624	\$1,311	\$933	\$1,508	55-59	\$694	\$1,457	\$1,037	\$1,676	55-59	\$763	\$1,602	\$1,141	\$1,843
60-64	\$770	\$1,463	\$1,030	\$1,708	60-64	\$856	\$1,626	\$1,145	\$1,898	60-64	\$941	\$1,788	\$1,259	\$2,087
65+	\$873	\$1,887	\$1,313	\$2,074	65+	\$970	\$2,097	\$1,458	\$2,305	65+	\$1,067	\$2,306	\$1,604	\$2,535
\$5 PLAN					\$5 PLAN					\$5 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$334	\$933	\$918	\$1,299	<30	\$371	\$1,037	\$1,020	\$1,443	<30	\$408	\$1,140	\$1,122	\$1,587
30-39	\$369	\$1,003	\$944	\$1,436	30-39	\$410	\$1,114	\$1,048	\$1,595	30-39	\$451	\$1,226	\$1,153	\$1,755
40-49	\$476	\$1,096	\$905	\$1,446	40-49	\$529	\$1,217	\$1,005	\$1,606	40-49	\$582	\$1,339	\$1,106	\$1,767
50-54	\$620	\$1,289	\$1,022	\$1,648	50-54	\$689	\$1,432	\$1,136	\$1,830	50-54	\$758	\$1,575	\$1,250	\$2,013
55-59	\$784	\$1,646	\$1,172	\$1,893	55-59	\$871	\$1,829	\$1,302	\$2,103	55-59	\$958	\$2,011	\$1,432	\$2,313
60-64	\$966	\$1,835	\$1,292	\$2,142	60-64	\$1,074	\$2,040	\$1,436	\$2,381	60-64	\$1,181	\$2,243	\$1,580	\$2,618
65+	\$1,096	\$2,368	\$1,648	\$2,603	65+	\$1,218	\$2,632	\$1,831	\$2,893	65+	\$1,340	\$2,895	\$2,014	\$3,182

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

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

¹Risk adjustment factor

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	MOST POPULAR DEDUCTIBLE PLAN W/HSA		
	\$30/\$3,000 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,000 PLAN W/HSA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$3,000/\$6,000 ¹	\$2,700/\$5,450 ¹	\$2,000/\$4,000 ²
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM³ Individual/Family	\$5,950/\$11,900 ¹	\$4,500/\$9,000 ¹	\$3,500/\$7,000 ²
IN THE MEDICAL OFFICE Office visits Preventive exams ⁴ Maternity/Prenatal care ^{4,5} Well-child preventive care visits ^{4,6} Vaccines (immunizations) ⁴ Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 \$10 \$10 \$0 \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$50 (after deductible) \$250 (after deductible)	\$0 (after deductible) \$0 \$0 \$0 \$0 \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$50 (after deductible) \$150 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)	\$100 (after deductible) \$100 (after deductible)
PRESCRIPTIONS⁷ Generic Brand-name	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 30-day supply) \$10 (after deductible) \$30 (after deductible)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible) 30% per admission (after deductible)	\$450 per day (after deductible) \$0 per admission (after deductible)	\$300 per day (after deductible) \$0 per admission (after deductible)
MENTAL HEALTH SERVICES In the medical office In the hospital	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$300 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$450 per day (after deductible)	\$0 (after deductible for individual therapy) \$300 per day (after deductible)
OTHER Certain durable medical equipment (DME) ⁸ Optical (eyewear) ⁹ Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

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

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

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

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

⁴This service is not subject to a deductible.

⁵Scheduled prenatal visits

⁶Well-child visits through age 23 months

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

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

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

KAISER PERMANENTE HSA-QUALIFIED DEDUCTIBLE HMO PLANS RATE AREA 1

EFFECTIVE 7/1/10-12/1/10

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$3,000 PLAN WITH HSA					\$30/\$3,000 PLAN WITH HSA					\$30/\$3,000 PLAN WITH HSA				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$116	\$317	\$262	\$382	<30	\$128	\$351	\$290	\$423	<30	\$141	\$387	\$320	\$466
30-39	\$137	\$365	\$276	\$427	30-39	\$152	\$406	\$307	\$475	30-39	\$167	\$446	\$337	\$522
40-49	\$185	\$377	\$289	\$479	40-49	\$205	\$419	\$321	\$532	40-49	\$226	\$461	\$353	\$586
50-54	\$247	\$512	\$338	\$567	50-54	\$274	\$569	\$375	\$630	50-54	\$302	\$626	\$413	\$693
55-59	\$306	\$637	\$397	\$698	55-59	\$340	\$707	\$441	\$775	55-59	\$374	\$778	\$485	\$853
60-64	\$393	\$786	\$486	\$870	60-64	\$436	\$873	\$539	\$966	60-64	\$480	\$960	\$593	\$1,062
65+	\$476	\$1,085	\$565	\$1,138	65+	\$529	\$1,206	\$628	\$1,265	65+	\$582	\$1,327	\$691	\$1,392
\$0/\$2,700 PLAN WITH HSA					\$0/\$2,700 PLAN WITH HSA					\$0/\$2,700 PLAN WITH HSA				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$131	\$358	\$296	\$431	<30	\$145	\$397	\$328	\$478	<30	\$160	\$438	\$362	\$528
30-39	\$154	\$412	\$311	\$482	30-39	\$172	\$459	\$347	\$537	30-39	\$189	\$505	\$381	\$591
40-49	\$209	\$426	\$327	\$541	40-49	\$232	\$473	\$363	\$601	40-49	\$255	\$521	\$399	\$662
50-54	\$279	\$579	\$382	\$641	50-54	\$310	\$643	\$424	\$712	50-54	\$341	\$708	\$467	\$784
55-59	\$346	\$720	\$449	\$789	55-59	\$385	\$800	\$499	\$877	55-59	\$423	\$880	\$548	\$965
60-64	\$444	\$888	\$549	\$983	60-64	\$493	\$987	\$609	\$1,092	60-64	\$542	\$1,085	\$670	\$1,201
65+	\$538	\$1,227	\$639	\$1,287	65+	\$598	\$1,363	\$710	\$1,430	65+	\$658	\$1,500	\$781	\$1,574
\$0/\$2,000 PLAN WITH HSA					\$0/\$2,000 PLAN WITH HSA					\$0/\$2,000 PLAN WITH HSA				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$161	\$441	\$364	\$531	<30	\$179	\$490	\$405	\$590	<30	\$197	\$539	\$445	\$649
30-39	\$190	\$508	\$383	\$595	30-39	\$211	\$564	\$426	\$660	30-39	\$232	\$620	\$468	\$726
40-49	\$257	\$524	\$402	\$666	40-49	\$285	\$582	\$446	\$740	40-49	\$314	\$641	\$491	\$814
50-54	\$343	\$712	\$470	\$788	50-54	\$381	\$791	\$522	\$876	50-54	\$419	\$870	\$574	\$963
55-59	\$426	\$886	\$552	\$971	55-59	\$473	\$984	\$613	\$1,079	55-59	\$521	\$1,083	\$675	\$1,187
60-64	\$546	\$1,093	\$675	\$1,209	60-64	\$606	\$1,213	\$749	\$1,342	60-64	\$667	\$1,335	\$825	\$1,477
65+	\$662	\$1,509	\$786	\$1,583	65+	\$736	\$1,678	\$873	\$1,760	65+	\$809	\$1,845	\$960	\$1,935

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 7/1/10–12/1/10

FEATURES	MOST POPULAR DEDUCTIBLE PLAN		
	\$40/\$2,000 PLAN MEMBER PAYS	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,000 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,000/\$4,000	\$1,500/\$3,000	\$1,000/\$2,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM^{1,2} Individual/Family	\$4,500/\$9,000	\$3,500/\$7,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE			
Office visits ³	\$40	\$30	\$30
Preventive exams ³	\$40	\$30	\$30
Maternity/Prenatal care ^{3,4}	\$0	\$0	\$0
Well-child preventive care visits ^{3,5}	\$0	\$0	\$0
Vaccines (immunizations) ³	\$0	\$0	\$0
Allergy injections	\$5 (after deductible)	\$5 (after deductible)	\$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$40 (after deductible)	\$30 (after deductible)	\$30 (after deductible)
Most labs and imaging	\$10 (after deductible)	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	30% (after deductible)	\$250 (after deductible)	\$250 (after deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	30% (after deductible)	\$100 (after deductible)	\$100 (after deductible)
Ambulance	\$100 (after deductible)	\$75 (after deductible)	\$75 (after deductible)
PRESCRIPTIONS^{3,6}	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	\$10	\$10	\$10
Brand-name	\$35	\$30	\$30
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
Skilled nursing facility care (up to 60 days per benefit period)	30% per admission (after deductible)	\$50 per day (after deductible)	\$50 per day (after deductible)
MENTAL HEALTH SERVICES			
In the medical office ³	\$40 (for individual therapy) \$20 (for group therapy)	\$30 (for individual therapy) \$15 (for group therapy)	\$30 (for individual therapy) \$15 (for group therapy)
In the hospital	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office ³	\$40 (for individual therapy)	\$30 (for individual therapy)	\$30 (for individual therapy)
In the hospital (detoxification only)	30% per admission (after deductible)	\$500 per day (after deductible)	\$500 per day (after deductible)
OTHER			
Certain durable medical equipment (DME) ⁷	Not covered	Not covered	Not covered
Optical (eyewear) ⁸	Not covered	Not covered	Not covered
Vision exam ³	\$40	\$30	\$30
Home health care ³ (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0
Hospice care ³	\$0	\$0	\$0

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

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

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

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

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

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

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

KAISER PERMANENTE DEDUCTIBLE HMO PLANS RATE AREA 1

EFFECTIVE 7/1/10-12/1/10

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

Monthly rates for groups new to Kaiser Permanente														
16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$40/\$2,000 PLAN					\$40/\$2,000 PLAN					\$40/\$2,000 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$147	\$403	\$333	\$486	<30	\$164	\$448	\$371	\$540	<30	\$180	\$493	\$407	\$594
30-39	\$174	\$465	\$351	\$544	30-39	\$193	\$516	\$390	\$604	30-39	\$213	\$569	\$430	\$666
40-49	\$235	\$480	\$368	\$610	40-49	\$261	\$533	\$408	\$677	40-49	\$288	\$587	\$450	\$746
50-54	\$314	\$652	\$430	\$722	50-54	\$349	\$725	\$478	\$803	50-54	\$384	\$797	\$526	\$882
55-59	\$390	\$811	\$506	\$889	55-59	\$433	\$901	\$561	\$988	55-59	\$477	\$992	\$618	\$1,087
60-64	\$500	\$1,001	\$618	\$1,108	60-64	\$555	\$1,111	\$686	\$1,229	60-64	\$611	\$1,223	\$755	\$1,353
65+	\$606	\$1,382	\$719	\$1,450	65+	\$674	\$1,536	\$800	\$1,611	65+	\$741	\$1,690	\$879	\$1,773
\$30/\$1,500 PLAN					\$30/\$1,500 PLAN					\$30/\$1,500 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$158	\$432	\$357	\$520	<30	\$175	\$479	\$396	\$577	<30	\$193	\$528	\$436	\$636
30-39	\$186	\$497	\$376	\$582	30-39	\$207	\$553	\$418	\$647	30-39	\$228	\$609	\$460	\$713
40-49	\$252	\$514	\$394	\$653	40-49	\$280	\$571	\$438	\$725	40-49	\$308	\$628	\$482	\$798
50-54	\$336	\$698	\$460	\$773	50-54	\$374	\$776	\$512	\$859	50-54	\$411	\$853	\$563	\$944
55-59	\$417	\$868	\$541	\$951	55-59	\$464	\$965	\$602	\$1,058	55-59	\$510	\$1,061	\$661	\$1,163
60-64	\$535	\$1,071	\$661	\$1,185	60-64	\$594	\$1,189	\$734	\$1,316	60-64	\$654	\$1,309	\$808	\$1,448
65+	\$649	\$1,480	\$770	\$1,553	65+	\$721	\$1,644	\$856	\$1,725	65+	\$793	\$1,808	\$941	\$1,897
\$30/\$1,000 PLAN					\$30/\$1,000 PLAN					\$30/\$1,000 PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$184	\$504	\$416	\$607	<30	\$204	\$559	\$462	\$674	<30	\$225	\$616	\$509	\$742
30-39	\$217	\$580	\$438	\$679	30-39	\$241	\$644	\$487	\$754	30-39	\$265	\$709	\$535	\$830
40-49	\$294	\$600	\$460	\$762	40-49	\$326	\$666	\$510	\$846	40-49	\$359	\$732	\$561	\$930
50-54	\$392	\$814	\$537	\$901	50-54	\$436	\$905	\$597	\$1,002	50-54	\$479	\$995	\$656	\$1,101
55-59	\$487	\$1,012	\$631	\$1,109	55-59	\$541	\$1,125	\$701	\$1,233	55-59	\$595	\$1,237	\$771	\$1,356
60-64	\$624	\$1,249	\$771	\$1,382	60-64	\$693	\$1,387	\$857	\$1,535	60-64	\$762	\$1,525	\$942	\$1,687
65+	\$757	\$1,726	\$898	\$1,811	65+	\$841	\$1,917	\$998	\$2,011	65+	\$925	\$2,109	\$1,098	\$2,212

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 7/1/10–12/1/10

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

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

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

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

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

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

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

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

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

KAISER PERMANENTE DEDUCTIBLE HMO PLANS WITH HRA RATE AREA 1

EFFECTIVE 7/1/10-12/1/10

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

Monthly rates for groups new to Kaiser Permanente														
16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$2,500 PLAN WITH HRA ²					\$30/\$2,500 PLAN WITH HRA ²					\$30/\$2,500 PLAN WITH HRA ²				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$150	\$411	\$340	\$495	<30	\$167	\$457	\$378	\$551	<30	\$184	\$503	\$416	\$606
30-39	\$177	\$474	\$358	\$555	30-39	\$197	\$527	\$398	\$617	30-39	\$217	\$580	\$438	\$679
40-49	\$240	\$490	\$375	\$622	40-49	\$267	\$544	\$417	\$691	40-49	\$293	\$598	\$458	\$760
50-54	\$320	\$665	\$438	\$736	50-54	\$356	\$739	\$488	\$818	50-54	\$392	\$813	\$537	\$900
55-59	\$398	\$827	\$516	\$907	55-59	\$442	\$919	\$573	\$1,007	55-59	\$486	\$1,011	\$630	\$1,108
60-64	\$510	\$1,020	\$630	\$1,129	60-64	\$566	\$1,133	\$700	\$1,254	60-64	\$623	\$1,247	\$770	\$1,380
65+	\$618	\$1,409	\$733	\$1,478	65+	\$687	\$1,566	\$815	\$1,643	65+	\$756	\$1,723	\$897	\$1,807
\$30/\$1,500 PLAN WITH HRA ²					\$30/\$1,500 PLAN WITH HRA ²					\$30/\$1,500 PLAN WITH HRA ²				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$168	\$460	\$380	\$554	<30	\$186	\$510	\$422	\$615	<30	\$205	\$561	\$464	\$676
30-39	\$198	\$529	\$400	\$619	30-39	\$220	\$588	\$444	\$688	30-39	\$242	\$647	\$489	\$757
40-49	\$268	\$547	\$419	\$695	40-49	\$298	\$608	\$466	\$772	40-49	\$328	\$669	\$513	\$850
50-54	\$358	\$743	\$490	\$823	50-54	\$398	\$826	\$545	\$914	50-54	\$437	\$908	\$599	\$1,005
55-59	\$444	\$924	\$576	\$1,013	55-59	\$494	\$1,027	\$640	\$1,126	55-59	\$543	\$1,129	\$704	\$1,238
60-64	\$569	\$1,139	\$703	\$1,260	60-64	\$633	\$1,267	\$782	\$1,402	60-64	\$696	\$1,393	\$860	\$1,541
65+	\$691	\$1,575	\$820	\$1,652	65+	\$767	\$1,749	\$910	\$1,835	65+	\$844	\$1,925	\$1,002	\$2,019

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 7/1/10–12/1/10
Nonparticipating
providers
(out-of-network)*

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)*	EFFECTIVE 7/1/10–12/1/10 Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$0		\$500/\$1,500
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM^{2,3} Individual/Family	\$3,000/\$6,000	\$3,000/\$9,000 ⁴	\$6,000/\$18,000 ⁴
MAXIMUM BENEFIT WHILE INSURED	Unlimited		\$2 million ⁵
IN THE MEDICAL OFFICE			
Office visits	\$35	\$45	50%
Routine adult physical exams	\$35	\$45	Not covered
Adult preventive screening exam	\$35	\$45	50%
Maternity/Prenatal care ⁶	\$0	\$25	50%
Well-child preventive care visits	\$0 ⁷	\$25 ⁸	50% ⁸
Vaccines (immunizations)	\$0	Not covered	Not covered
Allergy injections	\$5	\$25	50%
Infertility services ⁹	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$35	\$45 ¹⁰	50% ¹⁰
Most labs and imaging	\$10	30%	50%
MRI/CT/PET	\$50	30%	50%
Outpatient surgery	\$100	30%	50% ¹¹
EMERGENCY SERVICES			
Emergency Department visits (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		
PRESCRIPTIONS¹² (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies)	Obtained at participating MedImpact pharmacies ¹³	Obtained at non-Kaiser Permanente and non-MedImpact pharmacies
Generic	\$10	\$15	Not covered
Brand-name	\$35	\$40	Not covered
Nonformulary	\$50	\$60	Not covered
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	\$200 per day	30%	50% ¹⁵
Skilled nursing facility care ¹⁴	\$0	30%	50%
MENTAL HEALTH SERVICES¹⁶			
In the medical office	\$35 individual therapy \$17 group therapy	\$45 per individual therapy visit \$45 group therapy	50% per individual therapy visit 50% group therapy
In the hospital	\$200 per day	30%	50%
CHEMICAL DEPENDENCY SERVICES			
In the medical office	\$35 individual therapy \$5 group therapy	\$45 per individual therapy visit \$45 group therapy	50% per individual therapy visit 50% group therapy
In the hospital	\$200 per day	30%	50%
OTHER			
Certain durable medical equipment (DME) ¹⁷	\$0	30% ¹⁸	50% ¹⁸
Prosthetics, orthotics, and special footwear	\$40	Not covered	Not covered
Optical (eyewear)	Not covered ¹⁹	Not covered	Not covered
Vision exam	\$35	Not covered	Not covered
Home health care	\$0 (up to 100 two-hour visits per calendar year)	20% ²⁰	20% ²⁰
Hospice care	\$0	30% ²¹	50% ²¹

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

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

KAISER PERMANENTE \$35 POS PLAN RATE AREA 1

EFFECTIVE 7/1/10–12/1/10

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ²² .90					6 to 15 enrolling employees RAF ²² 1.00					5 or fewer enrolling employees RAF ²² 1.10				
\$35 POS PLAN					\$35 POS PLAN					\$35 POS PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$444	\$1,257	\$1,144	\$1,636	<30	\$493	\$1,396	\$1,271	\$1,817	<30	\$542	\$1,536	\$1,397	\$1,999
30–39	\$509	\$1,396	\$1,192	\$1,834	30–39	\$565	\$1,550	\$1,324	\$2,037	30–39	\$622	\$1,706	\$1,456	\$2,241
40–49	\$665	\$1,478	\$1,166	\$1,902	40–49	\$739	\$1,643	\$1,295	\$2,114	40–49	\$813	\$1,807	\$1,425	\$2,325
50–54	\$876	\$1,826	\$1,366	\$2,224	50–54	\$973	\$2,029	\$1,517	\$2,471	50–54	\$1,071	\$2,232	\$1,670	\$2,718
55–59	\$1,097	\$2,304	\$1,580	\$2,624	55–59	\$1,219	\$2,560	\$1,756	\$2,916	55–59	\$1,340	\$2,815	\$1,931	\$3,207
60–64	\$1,380	\$2,673	\$1,779	\$3,027	60–64	\$1,533	\$2,970	\$1,976	\$3,363	60–64	\$1,687	\$3,267	\$2,174	\$3,699
65+	\$1,669	\$3,680	\$2,217	\$3,842	65+	\$1,854	\$4,088	\$2,463	\$4,268	65+	\$2,040	\$4,498	\$2,710	\$4,696

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

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

*Based on maximum allowable charge for covered services

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

¹Deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied.

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

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

⁴The family out-of-pocket maximum equals three times the individual out-of-pocket maximum for family contracts of three or more members. Family contracts with two members will require each member to satisfy the individual out-of-pocket maximum.

⁵Maximum benefit while insured is \$2 million combined for services provided by PHCS network and nonparticipating providers.

⁶Scheduled prenatal visits and the first postpartum visit.

⁷Well-child care is covered by Kaiser Permanente Plan providers (HMO) through age 23 months.

⁸Well-child care (ages 0 to 18) is exempt from deductibles from PHCS network providers and includes immunizations.

⁹In accordance with California law, health care plans and insurers are required to offer contract holders and policyholders the option to purchase coverage of infertility treatment (excluding in vitro fertilization). For details regarding this optional coverage, including how you may elect this coverage and the amount of additional rates, please contact your broker or the Account Management Team at 1-800-790-4661.

¹⁰All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.

¹¹Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.

¹²A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

Nonformulary prescriptions that are not covered as an HMO benefit are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.

¹³Participating MedImpact pharmacy copayments and deductibles are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the OOPM. Select prescription medications are excluded from coverage. Please consult your participating pharmacy directory for a current list of participating pharmacies.

¹⁴Care in a skilled nursing facility is limited to 100 days per benefit period.

¹⁵Kaiser Permanente Insurance Company pays a maximum of \$600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

¹⁶Visit or day limits do not apply to covered services associated with mental health or alcohol/chemical dependency as described in the *Evidence of Coverage* and the KPIC *Certificate of Insurance*.

¹⁷Please refer to the *Evidence of Coverage* and the *Certificate of Insurance* for more information. DME is limited to a combined maximum of \$2,000 per calendar year for services provided by PHCS network and nonparticipating providers, excluding diabetic testing supplies and equipment.

¹⁸Durable medical equipment benefit is limited to \$2,000 maximum per calendar year for services from PHCS network and nonparticipating providers combined, excluding diabetic testing supplies and equipment.

¹⁹Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

²⁰Home health care is limited to a maximum of 100 visits per calendar year combined for services provided by PHCS network and nonparticipating providers. Deductible amount is limited to a maximum of \$50 per calendar year.

²¹Hospice care is limited to a 180-day lifetime benefit maximum for services from PHCS network and nonparticipating providers combined.

²²Risk adjustment factor

HMO exclusions and limitations

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

KAISER PERMANENTE \$40/\$2,500 PPO INSURANCE PLAN WITH HSA OPTION

PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	PHCS network (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,500/\$5,000	\$3,500/\$7,000
ANNUAL OUT-OF-POCKET MAXIMUM² Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
MAXIMUM BENEFIT WHILE INSURED³	\$5 million	
HOSPITAL CARE Room, board, and critical care units Imaging, including X-rays and lab tests Transplants Physician, surgeon, and surgical services Nursing care, anesthesia, and inpatient prescribed drugs	30% 30% 30% 30% 30%	50% ⁴ 50% ⁴ 50% ⁴ 50% 50% ⁴
OUTPATIENT CARE Physician office visits Routine adult physical exams Adult preventive screening exam ⁵ Well-child preventive care visits (through age 18) ⁷ Pediatric visits Outpatient surgery Allergy testing visits Allergy injection visits Gynecological visits Maternity/Scheduled prenatal care and first postpartum visit Imaging, including X-rays Lab tests Eye exams for eyeglass prescriptions Hearing exams Occupational, physical, respiratory, and speech therapy visits ⁹ Diabetic day care management	\$40 copay \$40 copay ^{5,6} \$40 copay \$25 copay \$40 copay 30% 30% 30% \$40 copay 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% 50% 50% 50% ⁸ 50% 50% 50% 50% 50% 50% Not covered Not covered 50%
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service ¹⁰ Nonemergency urgent care	\$100 copay, then 30% (copay waived if admitted) 30% 30% 30%	\$100 copay, then 30% (copay waived if admitted) 30% 30% 30%
PRESCRIPTIONS¹¹ Generic drugs Brand-name drugs Self-administered injectable medications ¹³ Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹² \$15 copay (maximum 30-day supply) \$35 copay (maximum 30-day supply) 30% \$30 copay (maximum 100-day supply) \$70 copay (maximum 100-day supply)	Non-MedImpact pharmacy Not covered Not covered Not covered Not covered Not covered
MENTAL HEALTH CARE Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child) Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	\$40 copay \$40 copay	50% ⁴ 50%
ALCOHOL AND CHEMICAL DEPENDENCY Inpatient hospitalization Outpatient visits	30% \$40 copay	50% ⁴ 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 ¹⁴ Durable medical equipment (DME) ¹⁵ Prosthetics, orthotics, and special footwear Diabetic equipment and supplies ¹⁶	30% 20% 30% 30% 30% 30%	50% 20% Not covered 50% 50% 50% 30%

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

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 RAF ¹⁷ .90					6 to 15 enrolling employees RAF ¹⁷ 1.00					5 or fewer enrolling employees RAF ¹⁷ 1.10				
\$40/\$2,500 PPO INSURANCE PLAN WITH HSA					\$40/\$2,500 PPO INSURANCE PLAN WITH HSA					\$40/\$2,500 PPO INSURANCE PLAN WITH HSA				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$326	\$949	\$705	\$1,065	<30	\$362	\$1,055	\$784	\$1,184	<30	\$398	\$1,160	\$862	\$1,302
30–39	\$402	\$1,121	\$781	\$1,235	30–39	\$446	\$1,245	\$868	\$1,372	30–39	\$491	\$1,370	\$955	\$1,509
40–49	\$537	\$1,184	\$823	\$1,368	40–49	\$597	\$1,316	\$915	\$1,520	40–49	\$657	\$1,448	\$1,006	\$1,673
50–54	\$723	\$1,516	\$947	\$1,618	50–54	\$804	\$1,685	\$1,053	\$1,798	50–54	\$884	\$1,853	\$1,157	\$1,978
55–59	\$891	\$1,872	\$1,113	\$1,970	55–59	\$990	\$2,080	\$1,236	\$2,188	55–59	\$1,089	\$2,288	\$1,360	\$2,407
60–64	\$1,161	\$2,322	\$1,382	\$2,417	60–64	\$1,290	\$2,580	\$1,535	\$2,686	60–64	\$1,419	\$2,837	\$1,689	\$2,954
65+	\$1,444	\$3,368	\$1,663	\$3,457	65+	\$1,605	\$3,743	\$1,849	\$3,842	65+	\$1,765	\$4,117	\$2,033	\$4,226

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

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

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

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

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

- ¹Calendar-year deductible amounts are separate for services provided by PHCS network and nonparticipating providers. Covered charges applied towards the satisfaction of the calendar-year deductible may also be applied towards the satisfaction of the out-of-pocket maximum.
- ²Out-of-pocket maximums are separate for services provided by PHCS network and nonparticipating providers.
- ³Maximum benefit amount while insured is combined for services provided by PHCS network and nonparticipating providers.
- ⁴Kaiser Permanente Insurance Company (KPIC) pays a maximum of \$600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.
- ⁵This service is not subject to a deductible.
- ⁶Routine adult physical exams are limited to one exam every 12 months and a benefit maximum of \$400 per covered exam.
- ⁷Well-child preventive care is exempt from deductibles and includes immunizations.
- ⁸Kaiser Permanente Insurance Company pays a maximum of \$400 per procedure for outpatient surgery services from nonparticipating providers.
- ⁹All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.
- ¹⁰The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of \$2,000 per calendar year for all services.
- ¹¹Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when **patient** requests brand-name drug and a generic version is available.
- ¹²MedImpact pharmacy copayments are subject to the satisfaction of the calendar-year deductible and out-of-pocket maximum. Drugs prescribed for family planning are subject to the calendar-year deductible. Select prescription drugs are excluded from coverage.
- ¹³Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.
- ¹⁴Benefits payable for treatment of infertility are limited to \$1,000 per lifetime combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.
- ¹⁵Durable 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.
- ¹⁶Diabetic 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.
- ¹⁷Risk 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 7/1/10–12/1/10

FEATURES	PHCS network (PPO)*	Nonparticipating providers (out-of-network)*
	MEMBER PAYS	MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family		\$1,000/\$2,000
ANNUAL OUT-OF-POCKET MAXIMUM^{1,2} Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
MAXIMUM BENEFIT WHILE INSURED³		\$5 million
HOSPITAL CARE Room, board, and critical care units Imaging, including X-rays and lab tests Transplants Physician, surgeon, and surgical services Nursing care, anesthesia, and inpatient prescribed drugs	30% 30% 30% 30% 30%	50% ⁴ 50% ⁴ 50% ⁴ 50% ⁴ 50% ⁴
OUTPATIENT CARE Physician office visits Routine adult physical exams Adult preventive screening exam Well-child preventive care visits (through age 18) Pediatric visits Outpatient surgery Allergy testing visits Allergy injection visits Gynecological visits Maternity/Scheduled prenatal care and first postpartum visit Imaging, including X-rays Lab tests Eye exams for eyeglass prescriptions Hearing exams Occupational, physical, respiratory, and speech therapy visits ¹⁰ Diabetic day care management	\$40 copay ^{5,6} \$40 copay ^{5,6,7} \$40 copay ^{5,6} \$25 copay ^{5,8} \$40 copay ^{5,6} 30% 30% 30% \$40 copay ^{5,6} 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% ⁶ 50% ⁸ 50% 50% ⁹ 50% 50% 50% 50% 50% Not covered Not covered Not covered 50% Not covered
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service ¹¹	\$100 copay, then 30% (copay waived if admitted) Covered at the nonparticipating providers level Covered at the nonparticipating providers level	\$100 copay, then 30% (copay waived if admitted) 30% 30%
PRESCRIPTIONS¹² Generic drugs Brand-name drugs deductible (pharmacy and mail order) Brand-name drugs Self-administered injectable medications ¹⁴ Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹³ \$15 copay ⁵ (maximum 30-day supply) \$200 deductible ⁵ \$35 copay ⁵ (maximum 30-day supply) 30% ⁵ \$30 copay ⁵ (maximum 100-day supply) \$70 copay ⁵ (maximum 100-day supply)	Non-MedImpact pharmacy Not covered Not covered Not covered Not covered Not covered Not covered
MENTAL HEALTH CARE Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child) Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	\$40 copay ^{5,6} \$40 copay ^{5,6}	50% ⁴ 50%
ALCOHOL AND CHEMICAL DEPENDENCY Inpatient hospitalization Outpatient visits	30% \$40 copay ^{5,6}	50% ⁴ 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) ¹⁵ Hospice care (180-day combined lifetime limit) Infertility services ¹⁶ Durable medical equipment (DME) ¹⁷ Prosthetics, orthotics, and special footwear Diabetic equipment and supplies ¹⁸	30% 20% 30% 30% 30% 30% 30%	50% 20% 50% 50% 50% 50% 30%

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

KAISER PERMANENTE

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

EFFECTIVE 7/1/10-12/1/10

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹⁹ .90					6 to 15 enrolling employees RAF ¹⁹ 1.00					5 or fewer enrolling employees RAF ¹⁹ 1.10				
\$40/\$1,000 PPO INSURANCE PLAN					\$40/\$1,000 PPO INSURANCE PLAN					\$40/\$1,000 PPO INSURANCE PLAN				
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$352	\$1,026	\$762	\$1,151	<30	\$391	\$1,140	\$847	\$1,279	<30	\$430	\$1,254	\$931	\$1,407
30-39	\$434	\$1,212	\$844	\$1,335	30-39	\$482	\$1,346	\$938	\$1,483	30-39	\$531	\$1,481	\$1,032	\$1,632
40-49	\$581	\$1,281	\$890	\$1,480	40-49	\$645	\$1,423	\$988	\$1,644	40-49	\$710	\$1,565	\$1,088	\$1,808
50-54	\$782	\$1,639	\$1,024	\$1,749	50-54	\$869	\$1,822	\$1,138	\$1,945	50-54	\$956	\$2,004	\$1,252	\$2,139
55-59	\$963	\$2,024	\$1,203	\$2,130	55-59	\$1,070	\$2,248	\$1,336	\$2,365	55-59	\$1,177	\$2,473	\$1,470	\$2,602
60-64	\$1,255	\$2,510	\$1,494	\$2,613	60-64	\$1,395	\$2,789	\$1,660	\$2,904	60-64	\$1,534	\$3,067	\$1,826	\$3,193
65+	\$1,562	\$3,642	\$1,799	\$3,738	65+	\$1,735	\$4,046	\$1,998	\$4,153	65+	\$1,909	\$4,451	\$2,199	\$4,569

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

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

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

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

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

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

²Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the PHCS network tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS network tier will not accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating providers tier.

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

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

⁵Brand-name drug deductible, copayments, and coinsurance paid for physician office visit or paid for prescriptions filled at participating pharmacies are not subject to, nor do they contribute toward, satisfaction of either the calendar-year deductible or the out-of-pocket maximum.

⁶This service is not subject to a deductible.

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

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

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

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

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

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

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

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

¹⁵Combined maximum deductible of \$50 per calendar year

¹⁶Benefits payable for treatment of infertility are limited to \$1,000 per calendar year combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.

¹⁷Durable 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.

¹⁸Diabetic 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.

¹⁹Risk adjustment factor

NOTES FOR KAISER PERMANENTE POS AND PPO PLANS

Precertification of services provided by PHCS network and nonparticipating providers

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

PHCS network and nonparticipating providers

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

Important information

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

Topics include:

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

NOTES FOR ALL PLANS

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

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan.

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

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

The following counties are entirely within Rate Area 1:

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

Portions of Contra Costa County are also within Rate Area 1.

94002	94301-06	95002	95196
94005	94309	95008-09	95201-13
94010-11	94401-04	95011	95215
94013-28	94497	95013-15	95219-20
94030	94501-02	95020-21	95227
94035	94536-46	95026	95230-31
94037-44	94550-52	95030-32	95234
94060-66	94555	95035-38	95236-37
94070	94557	95042	95240-42
94074	94560	95044	95253
94080	94566	95046	95258
94083	94568	95050-56	95267
94085-89	94577-80	95070-71	95269
94101-05	94586-88	95101	95296-97
94107-12	94601-15	95103	95304
94114-34	94617-24	95106	95320
94137	94649	95108-13	95330
94139-47	94659-62	95115-36	95336-37
94151	94666	95138-41	95366
94156	94701-10	95148	95376-78
94158-64	94712	95150-61	95385
94172	94720	95164	95391
94177	94801-08	95170	95686
94188	94820	95172-73	
94199	94850	95190-94	

businessnet.kp.org