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 7

KAISER PERMANENTE®

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]

[1]Multiple 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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Predictable out-of-pocket costs and no annual deductible to meet for medical services

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Lower monthly premiums, plus optional employee-owned savings accounts provide an innovative way to pay for qualified medical expenses

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Lower monthly premiums, and preventive care and doctor visits are not subject to the deductible

8–9 Deductible HMO plans with health reimbursement arrangement (HRA)
An IRS-regulated, employer-sponsored program that allows your employees to receive tax-free dollars[1] from you to pay for qualified medical expenses

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A point-of-service plan that gives employees access to Kaiser Permanente medical care with the added flexibility of choosing physicians and services from an external provider network or any licensed provider

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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.

14–15 $40/$1,000 PPO Insurance Plan
Choose a physician from a contracted network or any licensed nonparticipating provider.

17 RATE AREA 7 ZIP codes

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.

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

KAISER PERMANENTE

COPAYMENT PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	$50 PLAN MEMBER PAYS	MOST POPULAR COPAYMENT PLAN $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 MAXIMUM[1]					
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
PRESCRIPTIONS[4]	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)
Generic[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.

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

[2]Scheduled prenatal visits and the first postpartum visit

[3]Well-child visits through age 23 months

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

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

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

[7]Kaiser 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.

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

KAISER PERMANENTE

COPAYMENT PLANS RATE AREA 7

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

$50 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$191	$533	$525	$742
30–39	$211	$573	$539	$820
40–49	$272	$626	$517	$826
50–54	$354	$736	$584	$941
55–59	$448	$940	$670	$1,081
60–64	$552	$1,049	$738	$1,225
65+	$626	$1,353	$941	$1,487

$30 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$209	$583	$574	$811
30–39	$231	$627	$590	$897
40–49	$298	$685	$566	$904
50–54	$387	$805	$639	$1,029
55–59	$490	$1,029	$732	$1,183
60–64	$604	$1,147	$808	$1,339
65+	$685	$1,480	$1,030	$1,627

$20 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$228	$637	$627	$887
30–39	$252	$685	$644	$980
40–49	$325	$748	$618	$987
50–54	$423	$880	$698	$1,125
55–59	$535	$1,123	$800	$1,292
60–64	$660	$1,253	$883	$1,463
65+	$748	$1,617	$1,125	$1,778

$15 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$251	$701	$689	$975
30–39	$277	$753	$708	$1,078
40–49	$358	$823	$680	$1,086
50–54	$465	$967	$767	$1,236
55–59	$588	$1,235	$879	$1,420
60–64	$725	$1,377	$970	$1,608
65+	$823	$1,778	$1,237	$1,955

$5 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$311	$870	$855	$1,211
30–39	$344	$935	$880	$1,338
40–49	$444	$1,021	$844	$1,348
50–54	$578	$1,201	$953	$1,535
55–59	$730	$1,533	$1,091	$1,763
60–64	$901	$1,711	$1,205	$1,997
65+	$1,021	$2,207	$1,535	$2,426

6 to 15 enrolling employees RAF[1] 1.00

$50 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$212	$593	$583	$825
30–39	$234	$637	$599	$912
40–49	$302	$695	$574	$917
50–54	$394	$819	$650	$1,047
55–59	$498	$1,045	$744	$1,202
60–64	$614	$1,166	$821	$1,361
65+	$696	$1,504	$1,046	$1,653

$30 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$232	$648	$637	$902
30–39	$256	$696	$655	$996
40–49	$331	$761	$629	$1,004
50–54	$430	$894	$709	$1,143
55–59	$544	$1,142	$813	$1,314
60–64	$671	$1,274	$897	$1,487
65+	$761	$1,644	$1,144	$1,807

$20 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$254	$709	$697	$986
30–39	$280	$761	$716	$1,089
40–49	$361	$831	$686	$1,097
50–54	$470	$977	$775	$1,249
55–59	$594	$1,248	$888	$1,435
60–64	$733	$1,392	$980	$1,625
65+	$831	$1,796	$1,250	$1,974

$15 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$279	$779	$766	$1,084
30–39	$308	$837	$787	$1,198
40–49	$397	$914	$755	$1,206
50–54	$517	$1,075	$853	$1,374
55–59	$653	$1,372	$976	$1,578
60–64	$806	$1,531	$1,078	$1,787
65+	$914	$1,975	$1,374	$2,171

$5 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$346	$967	$951	$1,346
30–39	$382	$1,039	$977	$1,487
40–49	$493	$1,135	$937	$1,498
50–54	$642	$1,335	$1,059	$1,706
55–59	$811	$1,704	$1,213	$1,960
60–64	$1,001	$1,901	$1,339	$2,219
65+	$1,135	$2,453	$1,706	$2,697

5 or fewer enrolling employees RAF[1] 1.10

$50 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$233	$652	$641	$907
30–39	$258	$701	$659	$1,003
40–49	$333	$766	$632	$1,011
50–54	$433	$900	$714	$1,150
55–59	$547	$1,149	$818	$1,322
60–64	$675	$1,282	$903	$1,497
65+	$765	$1,654	$1,150	$1,818

$30 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$255	$713	$701	$992
30–39	$282	$766	$721	$1,097
40–49	$364	$837	$691	$1,105
50–54	$473	$984	$780	$1,258
55–59	$598	$1,256	$894	$1,445
60–64	$738	$1,402	$987	$1,637
65+	$837	$1,809	$1,258	$1,989

$20 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$279	$779	$766	$1,084
30–39	$308	$837	$787	$1,198
40–49	$397	$914	$755	$1,206
50–54	$517	$1,075	$853	$1,374
55–59	$654	$1,373	$978	$1,579
60–64	$806	$1,531	$1,078	$1,787
65+	$915	$1,977	$1,375	$2,173

$15 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$307	$857	$843	$1,192
30–39	$339	$921	$866	$1,318
40–49	$437	$1,005	$830	$1,326
50–54	$569	$1,182	$938	$1,511
55–59	$719	$1,510	$1,075	$1,737
60–64	$886	$1,683	$1,185	$1,965
65+	$1,005	$2,172	$1,511	$2,388

$5 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$381	$1,064	$1,046	$1,480
30–39	$421	$1,143	$1,076	$1,636
40–49	$543	$1,249	$1,031	$1,648
50–54	$706	$1,468	$1,164	$1,876
55–59	$893	$1,875	$1,335	$2,156
60–64	$1,101	$2,091	$1,472	$2,441
65+	$1,248	$2,697	$1,876	$2,965

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.

[1]Risk adjustment factor

KAISER PERMANENTE

HSA-QUALIFIED DEDUCTIBLE HMO PLANS

PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

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

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

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

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

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

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

[5]Scheduled prenatal visits

[6]Well-child visits through age 23 months

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

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

[9]Kaiser 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.

HSA-QUALIFIED DEDUCTIBLE HMO PLANS RATE AREA 7

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

Age	EE only	EE+S	EE+C	EE+S+C
$30/$3,000 PLAN WITH HSA				
<30	$108	$296	$244	$357
30–39	$128	$341	$258	$399
40–49	$173	$353	$270	$448
50–54	$230	$478	$315	$529
55–59	$286	$595	$371	$652
60–64	$367	$734	$454	$812
65+	$445	$1,014	$528	$1,064
$0/$2,700 PLAN WITH HSA				
<30	$122	$334	$276	$402
30–39	$144	$385	$291	$451
40–49	$195	$398	$305	$506
50–54	$260	$540	$356	$598
55–59	$323	$672	$419	$737
60–64	$414	$829	$512	$917
65+	$503	$1,146	$597	$1,202
$0/$2,000 PLAN WITH HSA				
<30	$158	$433	$358	$522
30–39	$187	$500	$377	$585
40–49	$253	$516	$396	$656
50–54	$338	$701	$463	$776
55–59	$419	$872	$543	$956
60–64	$537	$1,075	$664	$1,190
65+	$652	$1,486	$774	$1,559

6 to 15 enrolling employees RAF[1] 1.00

Age	EE only	EE+S	EE+C	EE+S+C
$30/$3,000 PLAN WITH HSA				
<30	$120	$329	$272	$396
30–39	$142	$379	$286	$444
40–49	$192	$392	$300	$498
50–54	$256	$531	$351	$588
55–59	$318	$661	$412	$725
60–64	$407	$815	$503	$902
65+	$494	$1,126	$586	$1,181
$0/$2,700 PLAN WITH HSA				
<30	$136	$372	$307	$448
30–39	$160	$428	$323	$501
40–49	$217	$442	$339	$562
50–54	$289	$600	$396	$664
55–59	$359	$747	$465	$819
60–64	$460	$921	$569	$1,019
65+	$558	$1,273	$662	$1,335
$0/$2,000 PLAN WITH HSA				
<30	$176	$482	$398	$581
30–39	$208	$556	$420	$651
40–49	$281	$573	$439	$728
50–54	$375	$779	$514	$862
55–59	$466	$969	$604	$1,062
60–64	$597	$1,195	$738	$1,322
65+	$724	$1,651	$859	$1,732

5 or fewer enrolling employees RAF[1] 1.10

Age	EE only	EE+S	EE+C	EE+S+C
$30/$3,000 PLAN WITH HSA				
<30	$132	$361	$299	$435
30–39	$156	$417	$315	$488
40–49	$211	$430	$330	$546
50–54	$282	$585	$386	$648
55–59	$350	$727	$454	$797
60–64	$448	$897	$554	$992
65+	$543	$1,239	$645	$1,300
$0/$2,700 PLAN WITH HSA				
<30	$149	$408	$337	$492
30–39	$176	$471	$355	$551
40–49	$238	$486	$372	$618
50–54	$318	$660	$436	$731
55–59	$395	$822	$512	$901
60–64	$506	$1,013	$626	$1,121
65+	$614	$1,400	$729	$1,469
$0/$2,000 PLAN WITH HSA				
<30	$193	$529	$437	$638
30–39	$229	$611	$462	$715
40–49	$309	$631	$483	$802
50–54	$413	$857	$566	$949
55–59	$512	$1,065	$664	$1,167
60–64	$657	$1,315	$812	$1,455
65+	$797	$1,817	$946	$1,906

Employee/Dependent codes

EE only = eligible employee only
EE+S = eligible employee plus spouse
EE+C = eligible employee plus child or children
EE+S+C = eligible employee plus spouse and child or children

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

[1] Risk adjustment factor

KAISER PERMANENTE
DEDUCTIBLE HMO PLANS PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	$40/$2,000 PLAN MEMBER PAYS	MOST POPULAR DEDUCTIBLE PLAN $30/$1,500 PLAN MEMBER PAYS	$30/$1,000 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]			
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.

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

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

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

[8]Kaiser 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 7

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

$40/$2,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$139	$380	$314	$458
30–39	$164	$438	$331	$513
40–49	$221	$451	$346	$573
50–54	$296	$614	$405	$680
55–59	$367	$763	$476	$836
60–64	$470	$941	$581	$1,041
65+	$571	$1,301	$678	$1,365

$30/$1,500 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$150	$411	$340	$495
30–39	$178	$475	$359	$556
40–49	$240	$490	$375	$623
50–54	$321	$666	$439	$737
55–59	$398	$828	$516	$908
60–64	$510	$1,021	$630	$1,130
65+	$619	$1,411	$735	$1,480

$30/$1,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$169	$463	$383	$558
30–39	$200	$534	$404	$625
40–49	$270	$551	$422	$700
50–54	$361	$749	$494	$829
55–59	$448	$932	$581	$1,022
60–64	$574	$1,149	$710	$1,271
65+	$697	$1,589	$827	$1,667

6 to 15 enrolling employees RAF[1] 1.00

$40/$2,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$154	$422	$349	$508
30–39	$182	$486	$367	$569
40–49	$246	$502	$385	$638
50–54	$328	$681	$449	$754
55–59	$408	$848	$529	$930
60–64	$523	$1,046	$646	$1,157
65+	$634	$1,445	$752	$1,516

$30/$1,500 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$167	$457	$378	$551
30–39	$197	$527	$398	$617
40–49	$267	$545	$418	$692
50–54	$356	$739	$488	$818
55–59	$442	$920	$573	$1,008
60–64	$567	$1,135	$701	$1,256
65+	$688	$1,568	$816	$1,645

$30/$1,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$188	$515	$426	$621
30–39	$222	$593	$448	$694
40–49	$300	$613	$469	$779
50–54	$401	$833	$549	$922
55–59	$498	$1,036	$646	$1,136
60–64	$638	$1,277	$789	$1,413
65+	$774	$1,765	$919	$1,852

5 or fewer enrolling employees RAF[1] 1.10

$40/$2,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$169	$463	$383	$558
30–39	$200	$535	$404	$626
40–49	$271	$553	$424	$702
50–54	$361	$750	$494	$830
55–59	$449	$933	$582	$1,023
60–64	$575	$1,151	$711	$1,274
65+	$697	$1,590	$827	$1,668

$30/$1,500 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$184	$503	$416	$606
30–39	$217	$580	$438	$679
40–49	$293	$598	$459	$760
50–54	$392	$814	$537	$901
55–59	$487	$1,012	$631	$1,109
60–64	$624	$1,249	$771	$1,382
65+	$756	$1,724	$897	$1,809

$30/$1,000 PLAN

Age	EE only	EE+S	EE+C	EE+S+C
<30	$207	$567	$468	$683
30–39	$244	$653	$493	$764
40–49	$330	$674	$516	$856
50–54	$441	$916	$604	$1,014
55–59	$548	$1,139	$710	$1,249
60–64	$702	$1,405	$868	$1,555
65+	$851	$1,941	$1,010	$2,036

Employee/Dependent codes

EE only = eligible employee only
EE+S = eligible employee plus spouse
EE+C = eligible employee plus child or children
EE+S+C = eligible employee plus spouse and child or children

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

[1] Risk adjustment factor

DEDUCTIBLE HMO PLANS WITH HRA PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	$30/$2,500 PLAN WITH HRA MEMBER PAYS	$30/$1,500 PLAN WITH HRA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]		
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	$30 (after deductible)	$30 (after deductible)
Preventive exams[3]	$30	$30
Maternity/Prenatal care[3,4]	$10	$10
Well-child preventive care visits[3,5]	$10	$10
Vaccines (immunizations)[3]	$0	$0
Allergy injections	$0 (after deductible)	$0 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	$30 (after deductible)	$30 (after deductible)
Most labs and imaging	$10 (after deductible)	$10 (after deductible)
MRI/CT/PET	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	20% (after deductible)	20% (after deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	$150 (after deductible)	$150 (after deductible)
PRESCRIPTIONS[6]	(up to a 30-day supply)	(up to a 30-day supply)
Generic[3]	$10	$10
Brand-name	$30	$30
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies	20% per admission (after deductible)	20% per admission (after deductible)
Skilled nursing facility care	20% per day (after deductible) (up to 100 days per benefit period)	20% per day (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES		
In the medical office	$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	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)[7]	Not covered	Not covered
Optical (eyewear)[8]	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

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.

[1] This plan carries an embedded deductible. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.
[2] The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).
[3] This service is not subject to a deductible.
[4] Scheduled prenatal visits and the first postpartum visit
[5] Well-child visits through age 23 months
[6] Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.
[7] Please refer to the *Evidence of Coverage* for more information; most DME is not covered.
[8] Kaiser 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 7

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

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$137	$375	$310	$452
30–39	$162	$433	$327	$507
40–49	$219	$447	$343	$568
50–54	$293	$608	$401	$673
55–59	$363	$755	$471	$828
60–64	$466	$932	$576	$1,031
65+	$565	$1,288	$670	$1,351

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$155	$424	$350	$511
30–39	$183	$488	$369	$571
40–49	$247	$504	$386	$640
50–54	$330	$685	$452	$758
55–59	$410	$852	$531	$934
60–64	$525	$1,051	$649	$1,163
65+	$637	$1,452	$756	$1,523

6 to 15 enrolling employees — RAF[1] 1.00

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$152	$417	$345	$503
30–39	$180	$481	$363	$563
40–49	$243	$496	$380	$630
50–54	$325	$675	$445	$747
55–59	$404	$840	$524	$921
60–64	$517	$1,035	$639	$1,145
65+	$627	$1,430	$744	$1,500

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$172	$471	$389	$567
30–39	$203	$542	$410	$635
40–49	$274	$560	$429	$711
50–54	$367	$761	$502	$842
55–59	$455	$946	$590	$1,037
60–64	$583	$1,167	$721	$1,291
65+	$707	$1,612	$839	$1,691

5 or fewer enrolling employees — RAF[1] 1.10

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$168	$459	$380	$553
30–39	$198	$529	$400	$619
40–49	$268	$547	$419	$695
50–54	$358	$743	$490	$822
55–59	$444	$923	$576	$1,012
60–64	$569	$1,139	$703	$1,260
65+	$690	$1,573	$819	$1,650

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

Age	EE only	EE+S	EE+C	EE+S+C
<30	$189	$518	$428	$624
30–39	$223	$596	$450	$698
40–49	$302	$616	$472	$783
50–54	$403	$837	$552	$927
55–59	$501	$1,041	$649	$1,141
60–64	$641	$1,283	$792	$1,420
65+	$778	$1,774	$923	$1,861

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.

[1]Risk adjustment factor

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

KAISER PERMANENTE
$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network) MEMBER PAYS	PHCS providers (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1] 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		
PRESCRIPTIONS[12] (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 SERVICES[16]			
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 7

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	$375	$1,062	$966	$1,382	<30	$416	$1,179	$1,073	$1,535	<30	$458	$1,297	$1,181	$1,688
30–39	$430	$1,179	$1,007	$1,549	30–39	$478	$1,310	$1,119	$1,721	30–39	$525	$1,441	$1,230	$1,893
40–49	$562	$1,249	$985	$1,607	40–49	$624	$1,388	$1,094	$1,786	40–49	$687	$1,527	$1,204	$1,965
50–54	$740	$1,543	$1,154	$1,879	50–54	$822	$1,714	$1,282	$2,087	50–54	$905	$1,886	$1,411	$2,297
55–59	$927	$1,946	$1,335	$2,217	55–59	$1,030	$2,163	$1,484	$2,464	55–59	$1,133	$2,379	$1,632	$2,710
60–64	$1,166	$2,259	$1,503	$2,558	60–64	$1,296	$2,510	$1,670	$2,842	60–64	$1,425	$2,760	$1,837	$3,125
65+	$1,410	$3,109	$1,873	$3,246	65+	$1,567	$3,455	$2,081	$3,607	65+	$1,723	$3,799	$2,289	$3,966

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.

[1] Deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. 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.

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

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

[4] The 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.

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

[6] Scheduled prenatal visits and the first postpartum visit.

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

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

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

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

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

[12] A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments. Nonformulary prescriptions that are not covered as an HMO benefit are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.

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

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

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

[16] Visit 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*.

[17] Please 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.

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

[19] Kaiser 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.

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

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

[22] Risk 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)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]		
Individual/Family	$2,500/$5,000	$3,500/$7,000
ANNUAL OUT-OF-POCKET MAXIMUM[2]		
Individual/Family	$5,000/$10,000	$10,000/$20,000
MAXIMUM BENEFIT WHILE INSURED[3]	$5 million	
HOSPITAL CARE		
Room, board, and critical care units	30%	50%[4]
Imaging, including X-rays and lab tests	30%	50%[4]
Transplants	30%	50%[4]
Physician, surgeon, and surgical services	30%	50%
Nursing care, anesthesia, and inpatient prescribed drugs	30%	50%[4]
OUTPATIENT CARE		
Physician office visits	$40 copay	50%
Routine adult physical exams	$40 copay[5,6]	Not covered
Adult preventive screening exam[5]	$40 copay	50%
Well-child preventive care visits (through age 18)[7]	$25 copay	50%
Pediatric visits	$40 copay	50%
Outpatient surgery	30%	50%[8]
Allergy testing visits	30%	50%
Allergy injection visits	30%	50%
Gynecological visits	$40 copay	50%
Maternity/Scheduled prenatal care and first postpartum visit	30%	50%
Imaging, including X-rays	30%	50%
Lab tests	30%	50%
Eye exams for eyeglass prescriptions	Not covered	Not covered
Hearing exams	Not covered	Not covered
Occupational, physical, respiratory, and speech therapy visits[9]	30%	50%
Diabetic day care management	30%	50%
EMERGENCY SERVICES		
Emergency Department visits	$100 copay, then 30% (copay waived if admitted)	$100 copay, then 30% (copay waived if admitted)
Emergency ambulance service	30%	30%
Medically necessary nonemergency ambulance service[10]	30%	30%
Nonemergency urgent care	30%	30%
PRESCRIPTIONS[11]	**MedImpact pharmacy[12]**	**Non–MedImpact pharmacy**
Generic drugs	$15 copay (maximum 30-day supply)	Not covered
Brand-name drugs	$35 copay (maximum 30-day supply)	Not covered
Self-administered injectable medications[13]	30%	Not covered
Mail-order generic drugs	$30 copay (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	$70 copay (maximum 100-day supply)	Not covered
MENTAL HEALTH CARE		
Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child)	$40 copay	50%[4]
Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	$40 copay	50%
ALCOHOL AND CHEMICAL DEPENDENCY		
Inpatient hospitalization	30%	50%[4]
Outpatient visits	$40 copay	50%
ADDITIONAL BENEFITS		
Care in a skilled nursing facility (60-day combined limit per calendar year)	30%	50%
Home health care (100-day combined limit per calendar year)	20%	20%
Hospice care (180-day combined lifetime limit)	30%	Not covered
Infertility services[14]	30%	50%
Durable medical equipment (DME)[15]	30%	50%
Prosthetics, orthotics, and special footwear	30%	50%
Diabetic equipment and supplies[16]	30%	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.

KAISER PERMANENTE

$40/$2,500 PPO INSURANCE PLAN WITH HSA OPTION RATE AREA 7

EFFECTIVE 7/1/10–12/1/10

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF[17] .90 — $40/$2,500 PPO INSURANCE PLAN WITH HSA

Age	EE only	EE+S	EE+C	EE+S+C
<30	$305	$888	$660	$997
30–39	$376	$1,049	$731	$1,156
40–49	$502	$1,107	$769	$1,279
50–54	$676	$1,418	$885	$1,513
55–59	$833	$1,750	$1,040	$1,841
60–64	$1,086	$2,171	$1,292	$2,260
65+	$1,351	$3,150	$1,556	$3,233

6 to 15 enrolling employees RAF[17] 1.00 — $40/$2,500 PPO INSURANCE PLAN WITH HSA

Age	EE only	EE+S	EE+C	EE+S+C
<30	$338	$986	$732	$1,107
30–39	$417	$1,164	$811	$1,283
40–49	$558	$1,231	$855	$1,422
50–54	$752	$1,576	$984	$1,682
55–59	$926	$1,945	$1,156	$2,046
60–64	$1,206	$2,412	$1,435	$2,511
65+	$1,501	$3,500	$1,729	$3,593

5 or fewer enrolling employees RAF[17] 1.10 — $40/$2,500 PPO INSURANCE PLAN WITH HSA

Age	EE only	EE+S	EE+C	EE+S+C
<30	$372	$1,084	$806	$1,217
30–39	$459	$1,281	$893	$1,411
40–49	$614	$1,354	$941	$1,564
50–54	$827	$1,734	$1,083	$1,851
55–59	$1,019	$2,140	$1,272	$2,252
60–64	$1,327	$2,654	$1,579	$2,763
65+	$1,651	$3,850	$1,902	$3,952

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.

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

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

[1] Calendar-year deductible amounts are separate for services provided by PHCS network and nonparticipating providers. Covered charges applied towards the satisfaction of the calendar-year deductible may also be applied towards the satisfaction of the out-of-pocket maximum.

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

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

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

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

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

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

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

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

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

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

[12] MedImpact pharmacy copayments are subject to the satisfaction of the calendar-year deductible and out-of-pocket maximum. Drugs prescribed for family planning are subject to the calendar-year deductible. Select prescription drugs are excluded from coverage.

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

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

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

[16] Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of $2,000 per calendar year.

[17] Risk adjustment factor

Important notice regarding the $40/$2,500 PPO Insurance Plan with HSA Option

This chart is a summary of the benefits for a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts (HSAs) in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, as then constituted or later amended. Enrollment in an HDHP that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Please consult with your employer about other eligibility requirements for establishing an HSA-qualified plan.

Please note: If you have other health coverage, including coverage under Medicare, in addition to the coverage under this Group Policy, you may not be eligible to establish or contribute to an HSA unless both coverages qualify as High Deductible Health Plans.

Kaiser Permanente Insurance Company (KPIC) does not provide tax advice. The California Department of Insurance does NOT in any way warrant that this plan meets the federal requirements.

Consult with your financial or tax adviser for tax advice or more information about your eligibility for an HSA.

KAISER PERMANENTE
$40/$1,000 PPO INSURANCE PLAN PLAN HIGHLIGHTS

EFFECTIVE 7/1/10–12/1/10

FEATURES	PHCS network (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]		
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 INSURED[3]	$5 million	
HOSPITAL CARE		
Room, board, and critical care units	30%	50%[4]
Imaging, including X-rays and lab tests	30%	50%[4]
Transplants	30%	50%[4]
Physician, surgeon, and surgical services	30%	50%
Nursing care, anesthesia, and inpatient prescribed drugs	30%	50%[4]
OUTPATIENT CARE		
Physician office visits	$40 copay[5,6]	50%
Routine adult physical exams	$40 copay[5,6,7]	Not covered
Adult preventive screening exam	$40 copay[5,6]	50%[6]
Well-child preventive care visits (through age 18)	$25 copay[5,8]	50%[8]
Pediatric visits	$40 copay[5,6]	50%
Outpatient surgery	30%	50%[9]
Allergy testing visits	30%	50%
Allergy injection visits	30%	50%
Gynecological visits	$40 copay[5,6]	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 30% (copay waived if admitted)	$100 copay, then 30% (copay waived if admitted)
Emergency ambulance service	Covered at the nonparticipating providers level	30%
Medically necessary nonemergency ambulance service[11]	Covered at the nonparticipating providers level	30%
PRESCRIPTIONS[12]	**MedImpact pharmacy**[13]	**Non–MedImpact pharmacy**
Generic drugs	$15 copay[5] (maximum 30-day supply)	Not covered
Brand-name drugs deductible (pharmacy and mail order)	$200 deductible[5]	Not covered
Brand-name drugs	$35 copay[5] (maximum 30-day supply)	Not covered
Self-administered injectable medications[14]	30%[5]	Not covered
Mail-order generic drugs	$30 copay[5] (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	$70 copay[5] (maximum 100-day supply)	Not covered
MENTAL HEALTH CARE		
Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child)	$40 copay[5,6]	50%[4]
Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	$40 copay[5,6]	50%
ALCOHOL AND CHEMICAL DEPENDENCY		
Inpatient hospitalization	30%	50%[4]
Outpatient visits	$40 copay[5,6]	50%
ADDITIONAL BENEFITS		
Care in a skilled nursing facility (60-day combined limit per calendar year)	30%	50%
Home health care (100-day combined limit per calendar year)[15]	20%	20%
Hospice care (180-day combined lifetime limit)	30%	50%
Infertility services[16]	30%	50%
Durable medical equipment (DME)[17]	30%	50%
Prosthetics, orthotics, and special footwear	30%	50%
Diabetic equipment and supplies[18]	30%	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 15 and 16.

KAISER PERMANENTE

$40/$1,000 PPO INSURANCE PLAN RATE AREA 7

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	$329	$959	$713	$1,076	<30	$366	$1,066	$792	$1,196	<30	$402	$1,172	$871	$1,315
30–39	$406	$1,133	$790	$1,248	30–39	$451	$1,259	$877	$1,387	30–39	$496	$1,385	$965	$1,526
40–49	$543	$1,197	$832	$1,383	40–49	$604	$1,331	$925	$1,538	40–49	$664	$1,464	$1,017	$1,691
50–54	$731	$1,533	$957	$1,636	50–54	$812	$1,703	$1,063	$1,818	50–54	$894	$1,874	$1,170	$2,000
55–59	$901	$1,893	$1,125	$1,992	55–59	$1,001	$2,103	$1,250	$2,213	55–59	$1,101	$2,313	$1,375	$2,434
60–64	$1,174	$2,347	$1,397	$2,443	60–64	$1,304	$2,608	$1,552	$2,715	60–64	$1,435	$2,869	$1,708	$2,987
65+	$1,460	$3,405	$1,682	$3,495	65+	$1,623	$3,784	$1,869	$3,884	65+	$1,785	$4,162	$2,056	$4,272

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.

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

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

[1] Calendar-year deductible amounts are 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[18] Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of $2,000 per calendar year.

[19] Risk adjustment factor

NOTES FOR KAISER PERMANENTE POS AND PPO PLANS

Precertification of services provided by PHCS network and nonparticipating providers

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

PHCS network and nonparticipating providers

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

Important information

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

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

NOTES FOR ALL PLANS

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

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.

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 7

Below is a listing of all ZIP codes within RATE AREA 7.

Portions of the following counties are within Rate Area 7:

Kern, Los Angeles, Tulare, and Ventura.

91301–11
91313
91316
91319–22
91324–31
91333–35
91337
91340–46
91350–62
91364–65
91367
91371–72
91376–77
91380–81
91383–87
91390
91392–96
91401–13
91416
91423
91426
91436
91470
91482
91495–96
91499
91601–12
91614–18
93001–07
93009–12
93015–16
93020–22
93030–36
93040–44
93060–66
93094
93099
93203
93205–06
93215–16
93220
93222
93224–26
93238
93240–41
93243
93249–52
93261
93263
93268
93276
93280
93285
93287
93301–09
93311–14
93380
93383–90
93501–02
93504–05
93510
93518–19
93531–32
93534–36
93539
93543–44
93550–53
93560–61
93563
93581
93584
93586
93590–91
93599

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