

# PLAN HIGHLIGHTS AND RATES

**Effective January to June 2009**

**2009 SMALL BUSINESS RATE AREA 1**

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**For new groups**

- Team up with Kaiser Permanente for the one-source answer to all your health care coverage needs.
- On these pages, you'll find an overview of available plan benefits for small businesses.
- A full listing of all Kaiser Permanente plans and benefits can be found in your 2009 Kaiser Foundation Health Plan *Evidence of Coverage* and your Kaiser Permanente Insurance Company *Certificate of Insurance*.

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

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

VERY  
POPULAR!

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## Deductible plans

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Lower monthly premiums and higher out-of-pocket expenses at the time of service

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An IRS-regulated, employer-sponsored program that allows your employees to receive tax-free dollars<sup>1</sup> from you to pay for covered medical expenses. Administrative fees apply.

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

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

# COPAYMENT PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

## MOST POPULAR COPAYMENT PLAN

FEATURES	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b>	\$0	\$0	\$0	\$0	\$0
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>1</sup></b> Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$3,000
<b>IN THE MEDICAL OFFICE</b>					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/Prenatal care <sup>2</sup>	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits <sup>3</sup>	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$5
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
<b>EMERGENCY SERVICES</b>					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
<b>PRESCRIPTIONS<sup>4</sup></b>	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)
Generic	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$10 <sup>5</sup>	\$5 <sup>5</sup>
Brand-name	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 <sup>5</sup>	\$25 <sup>5</sup>	\$15 <sup>5</sup>
<b>HOSPITAL CARE</b>					
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
<b>MENTAL HEALTH SERVICES<sup>6</sup></b>					
In the medical office (up to 20 visits per calendar year)	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital (up to 30 days per calendar year)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
<b>CHEMICAL DEPENDENCY SERVICES</b>					
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
<b>OTHER</b>					
Certain durable medical equipment (DME)	Not covered <sup>7</sup>	Not covered <sup>7</sup>	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered <sup>8</sup>	Not covered <sup>8</sup>	Not covered <sup>8</sup>	\$150 allowance <sup>9</sup>	\$150 allowance <sup>9</sup>
Vision exam	\$50	\$30	\$20	\$15	\$5
Home health care (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0	\$0	\$0
Hospice care	\$0	\$0	\$0	\$0	\$0

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

<sup>1</sup>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*).

<sup>2</sup>Scheduled prenatal visits and the first postpartum visit

<sup>3</sup>23 months or younger

<sup>4</sup>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.

<sup>5</sup>This service is not subject to a deductible.

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

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

<sup>8</sup>Kaiser Permanente members who are enrolled in this benefit plan 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](http://kp.org/2020) for Kaiser Permanente optical locations.

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

# COPAYMENT PLANS RATE AREA 1

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$50 PLAN</b>														
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	\$178	\$497	\$489	\$692	<30	\$198	\$553	\$544	\$769	<30	\$218	\$608	\$598	\$846
30–39	\$197	\$535	\$503	\$766	30–39	\$219	\$594	\$559	\$850	30–39	\$240	\$653	\$614	\$935
40–49	\$254	\$584	\$482	\$771	40–49	\$282	\$649	\$536	\$856	40–49	\$310	\$713	\$589	\$941
50–54	\$330	\$686	\$544	\$877	50–54	\$367	\$763	\$605	\$975	50–54	\$404	\$839	\$666	\$1,072
55–59	\$417	\$876	\$624	\$1,008	55–59	\$464	\$974	\$693	\$1,120	55–59	\$510	\$1,071	\$762	\$1,232
60–64	\$515	\$978	\$689	\$1,142	60–64	\$572	\$1,087	\$765	\$1,269	60–64	\$629	\$1,195	\$841	\$1,395
65+	\$584	\$1,262	\$878	\$1,387	65+	\$649	\$1,402	\$976	\$1,541	65+	\$714	\$1,542	\$1,073	\$1,695
<b>\$30 PLAN</b>														
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	\$195	\$544	\$535	\$757	<30	\$216	\$604	\$594	\$841	<30	\$238	\$665	\$654	\$925
30–39	\$215	\$585	\$550	\$837	30–39	\$239	\$650	\$611	\$930	30–39	\$263	\$715	\$672	\$1,023
40–49	\$278	\$639	\$528	\$843	40–49	\$308	\$709	\$586	\$936	40–49	\$339	\$780	\$644	\$1,030
50–54	\$361	\$751	\$596	\$960	50–54	\$401	\$834	\$662	\$1,066	50–54	\$442	\$918	\$729	\$1,173
55–59	\$457	\$959	\$683	\$1,103	55–59	\$507	\$1,065	\$758	\$1,225	55–59	\$558	\$1,172	\$834	\$1,348
60–64	\$563	\$1,070	\$753	\$1,249	60–64	\$626	\$1,189	\$837	\$1,388	60–64	\$688	\$1,307	\$920	\$1,526
65+	\$639	\$1,381	\$961	\$1,518	65+	\$710	\$1,534	\$1,067	\$1,686	65+	\$781	\$1,687	\$1,174	\$1,855
<b>\$20 PLAN</b>														
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	\$216	\$603	\$593	\$839	<30	\$240	\$670	\$659	\$932	<30	\$264	\$737	\$725	\$1,026
30–39	\$238	\$648	\$609	\$928	30–39	\$265	\$720	\$677	\$1,031	30–39	\$291	\$792	\$745	\$1,134
40–49	\$308	\$708	\$585	\$934	40–49	\$342	\$787	\$650	\$1,038	40–49	\$376	\$865	\$714	\$1,142
50–54	\$400	\$832	\$660	\$1,064	50–54	\$445	\$925	\$734	\$1,182	50–54	\$489	\$1,017	\$807	\$1,300
55–59	\$506	\$1,063	\$756	\$1,223	55–59	\$562	\$1,181	\$840	\$1,358	55–59	\$619	\$1,299	\$925	\$1,494
60–64	\$624	\$1,185	\$835	\$1,383	60–64	\$694	\$1,318	\$928	\$1,538	60–64	\$763	\$1,449	\$1,020	\$1,692
65+	\$708	\$1,530	\$1,064	\$1,682	65+	\$787	\$1,700	\$1,183	\$1,869	65+	\$865	\$1,870	\$1,300	\$2,056
<b>\$15 PLAN</b>														
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	\$232	\$648	\$637	\$902	<30	\$258	\$720	\$708	\$1,002	<30	\$284	\$792	\$779	\$1,102
30–39	\$256	\$696	\$655	\$996	30–39	\$285	\$774	\$728	\$1,108	30–39	\$313	\$851	\$800	\$1,218
40–49	\$331	\$761	\$629	\$1,004	40–49	\$367	\$845	\$698	\$1,115	40–49	\$404	\$930	\$768	\$1,227
50–54	\$430	\$894	\$709	\$1,143	50–54	\$478	\$994	\$788	\$1,271	50–54	\$526	\$1,093	\$867	\$1,397
55–59	\$544	\$1,142	\$813	\$1,313	55–59	\$604	\$1,269	\$903	\$1,460	55–59	\$665	\$1,396	\$994	\$1,606
60–64	\$671	\$1,274	\$897	\$1,487	60–64	\$745	\$1,415	\$996	\$1,652	60–64	\$820	\$1,557	\$1,097	\$1,818
65+	\$761	\$1,644	\$1,144	\$1,807	65+	\$845	\$1,826	\$1,270	\$2,007	65+	\$930	\$2,010	\$1,398	\$2,210
<b>\$5 PLAN</b>														
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	\$293	\$818	\$804	\$1,138	<30	\$325	\$908	\$893	\$1,264	<30	\$358	\$999	\$983	\$1,390
30–39	\$323	\$878	\$826	\$1,257	30–39	\$359	\$976	\$918	\$1,397	30–39	\$395	\$1,073	\$1,010	\$1,536
40–49	\$417	\$959	\$792	\$1,266	40–49	\$463	\$1,066	\$880	\$1,407	40–49	\$510	\$1,173	\$969	\$1,548
50–54	\$543	\$1,128	\$895	\$1,442	50–54	\$603	\$1,253	\$994	\$1,602	50–54	\$663	\$1,378	\$1,094	\$1,762
55–59	\$686	\$1,440	\$1,025	\$1,656	55–59	\$762	\$1,600	\$1,139	\$1,840	55–59	\$838	\$1,760	\$1,253	\$2,024
60–64	\$846	\$1,607	\$1,131	\$1,876	60–64	\$940	\$1,785	\$1,257	\$2,084	60–64	\$1,034	\$1,964	\$1,383	\$2,293
65+	\$959	\$2,073	\$1,442	\$2,279	65+	\$1,066	\$2,304	\$1,603	\$2,533	65+	\$1,173	\$2,534	\$1,763	\$2,786

**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.

<sup>1</sup>Risk adjustment factor

# DEDUCTIBLE PLANS WITH HSA OPTION PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

**MOST POPULAR DEDUCTIBLE PLAN**

FEATURES	\$30/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,700 PLAN W/HSA MEMBER PAYS	\$0/\$2,200 PLAN W/HSA MEMBER PAYS	\$0/\$1,500 PLAN W/HSA MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$2,700/\$5,450 <sup>1</sup>	\$2,700/\$5,450 <sup>1</sup>	\$2,200/\$4,400 <sup>2</sup>	\$1,500/\$3,000 <sup>2</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	N/A	N/A	N/A	N/A
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>3</sup></b> Self-only enrollment/Family enrollment	\$5,250/\$10,500	\$2,700/\$5,450	\$2,200/\$4,400	\$1,500/\$3,000
<b>IN THE MEDICAL OFFICE</b> Office visits Preventive exams Maternity/Prenatal care <sup>5</sup> Well-child preventive care visits <sup>6</sup> Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 <sup>4</sup> \$10 <sup>4</sup> \$10 <sup>4</sup> \$0 <sup>4</sup> \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)
<b>PRESCRIPTIONS<sup>7</sup></b> Generic Brand-name	(up to a 100-day supply) \$10 (after deductible) \$30 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)	(up to a 100-day supply) \$0 (after deductible) \$0 (after deductible)
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible) 30% per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)
<b>MENTAL HEALTH SERVICES<sup>8</sup></b> In the medical office (up to 20 visits per calendar year)  In the hospital (up to 30 days per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office  In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)
<b>OTHER</b> Certain durable medical equipment (DME) <sup>9</sup> Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered <sup>10</sup> \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered <sup>10</sup> \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

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

<sup>1</sup>Each family member becomes eligible for copayments after meeting his or her individual deductible.

<sup>2</sup>The entire family deductible must be met before copayments apply for individual family members.

<sup>3</sup>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*).

<sup>4</sup>This service is not subject to a deductible.

<sup>5</sup>Scheduled prenatal visits and the first postpartum visit

<sup>6</sup>23 months or younger

<sup>7</sup>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.

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

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

<sup>10</sup>Kaiser Permanente members who are enrolled in this benefit plan 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](http://kp.org/2020) for Kaiser Permanente optical locations.

# DEDUCTIBLE PLANS WITH HSA OPTION RATE AREA 1

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$2,700 PLAN WITH HSA</b>														
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	\$91	\$249	\$206	\$300	<30	\$101	\$276	\$229	\$333	<30	\$111	\$304	\$251	\$366
30–39	\$107	\$286	\$216	\$335	30–39	\$119	\$318	\$240	\$372	30–39	\$131	\$350	\$265	\$410
40–49	\$145	\$296	\$227	\$376	40–49	\$161	\$329	\$252	\$418	40–49	\$177	\$362	\$277	\$460
50–54	\$194	\$403	\$266	\$446	50–54	\$215	\$447	\$295	\$495	50–54	\$237	\$492	\$325	\$545
55–59	\$241	\$501	\$312	\$549	55–59	\$267	\$556	\$346	\$609	55–59	\$294	\$611	\$381	\$670
60–64	\$308	\$617	\$381	\$683	60–64	\$343	\$686	\$424	\$759	60–64	\$377	\$754	\$466	\$834
65+	\$374	\$853	\$444	\$895	65+	\$416	\$948	\$494	\$994	65+	\$457	\$1,042	\$542	\$1,093
<b>\$0/\$2,700 PLAN WITH HSA</b>														
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	\$103	\$281	\$233	\$339	<30	\$114	\$312	\$258	\$376	<30	\$125	\$343	\$284	\$413
30–39	\$121	\$324	\$245	\$379	30–39	\$135	\$360	\$272	\$421	30–39	\$148	\$396	\$299	\$464
40–49	\$164	\$335	\$257	\$426	40–49	\$182	\$372	\$285	\$473	40–49	\$200	\$409	\$313	\$520
50–54	\$219	\$455	\$300	\$504	50–54	\$243	\$505	\$333	\$559	50–54	\$268	\$556	\$367	\$615
55–59	\$272	\$566	\$353	\$620	55–59	\$302	\$628	\$392	\$688	55–59	\$332	\$691	\$431	\$757
60–64	\$348	\$697	\$430	\$771	60–64	\$387	\$775	\$478	\$858	60–64	\$426	\$852	\$527	\$943
65+	\$423	\$964	\$502	\$1,011	65+	\$470	\$1,071	\$558	\$1,124	65+	\$517	\$1,178	\$613	\$1,236
<b>\$0/\$2,200 PLAN WITH HSA</b>														
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	\$386	\$319	\$465
30–39	\$136	\$364	\$275	\$426	30–39	\$152	\$406	\$306	\$475	30–39	\$167	\$446	\$337	\$522
40–49	\$185	\$377	\$289	\$479	40–49	\$205	\$418	\$321	\$531	40–49	\$226	\$461	\$353	\$586
50–54	\$246	\$511	\$337	\$566	50–54	\$274	\$569	\$375	\$630	50–54	\$301	\$625	\$412	\$692
55–59	\$306	\$636	\$397	\$697	55–59	\$340	\$707	\$441	\$775	55–59	\$374	\$778	\$485	\$853
60–64	\$392	\$785	\$485	\$869	60–64	\$436	\$872	\$539	\$965	60–64	\$479	\$959	\$592	\$1,061
65+	\$476	\$1,085	\$565	\$1,138	65+	\$528	\$1,205	\$627	\$1,264	65+	\$581	\$1,325	\$690	\$1,390
<b>\$0/\$1,500 PLAN WITH HSA</b>														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$125	\$342	\$282	\$412	<30	\$138	\$379	\$313	\$457	<30	\$152	\$417	\$344	\$502
30–39	\$147	\$393	\$297	\$460	30–39	\$164	\$438	\$331	\$513	30–39	\$180	\$481	\$363	\$563
40–49	\$199	\$406	\$311	\$516	40–49	\$221	\$451	\$346	\$573	40–49	\$243	\$496	\$380	\$630
50–54	\$266	\$552	\$364	\$611	50–54	\$295	\$613	\$404	\$679	50–54	\$325	\$675	\$445	\$747
55–59	\$330	\$686	\$428	\$752	55–59	\$367	\$763	\$476	\$836	55–59	\$403	\$838	\$523	\$919
60–64	\$423	\$847	\$523	\$937	60–64	\$470	\$941	\$581	\$1,041	60–64	\$517	\$1,035	\$639	\$1,145
65+	\$513	\$1,170	\$609	\$1,227	65+	\$570	\$1,300	\$676	\$1,364	65+	\$627	\$1,430	\$744	\$1,500

**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.

<sup>1</sup>Risk adjustment factor

# DEDUCTIBLE PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

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

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

<sup>1</sup>Each family member becomes eligible for copayments after meeting his or her individual deductible.

<sup>2</sup>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*).

<sup>3</sup>This service is not subject to a deductible.

<sup>4</sup>Scheduled prenatal visits and the first postpartum visit

<sup>5</sup>23 months or younger

<sup>6</sup>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.

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

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

<sup>9</sup>Kaiser Permanente members who are enrolled in this benefit plan 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](http://kp.org/2020) for Kaiser Permanente optical locations.

# DEDUCTIBLE PLANS **RATE AREA 1**

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$1,500 PLAN</b>														
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	\$124	\$340	\$281	\$410	<30	\$138	\$378	\$313	\$456	<30	\$152	\$416	\$344	\$501
30–39	\$147	\$393	\$297	\$460	30–39	\$163	\$436	\$329	\$510	30–39	\$180	\$480	\$363	\$562
40–49	\$199	\$406	\$311	\$516	40–49	\$221	\$451	\$346	\$573	40–49	\$243	\$496	\$380	\$630
50–54	\$265	\$551	\$363	\$610	50–54	\$295	\$612	\$404	\$678	50–54	\$324	\$673	\$444	\$745
55–59	\$329	\$685	\$427	\$751	55–59	\$366	\$761	\$475	\$834	55–59	\$403	\$838	\$522	\$919
60–64	\$422	\$845	\$522	\$935	60–64	\$469	\$939	\$580	\$1,039	60–64	\$516	\$1,033	\$638	\$1,143
65+	\$512	\$1,168	\$608	\$1,225	65+	\$569	\$1,297	\$675	\$1,361	65+	\$626	\$1,427	\$743	\$1,497
<b>\$30/\$1,000 PLAN</b>														
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	\$163	\$447	\$369	\$539	<30	\$180	\$493	\$407	\$594
30–39	\$174	\$465	\$351	\$544	30–39	\$193	\$516	\$390	\$604	30–39	\$212	\$567	\$428	\$664
40–49	\$235	\$480	\$368	\$610	40–49	\$261	\$533	\$408	\$677	40–49	\$287	\$586	\$449	\$745
50–54	\$314	\$652	\$430	\$722	50–54	\$349	\$724	\$478	\$801	50–54	\$384	\$797	\$526	\$882
55–59	\$390	\$811	\$505	\$889	55–59	\$433	\$900	\$561	\$987	55–59	\$476	\$990	\$617	\$1,085
60–64	\$499	\$999	\$617	\$1,105	60–64	\$555	\$1,110	\$686	\$1,228	60–64	\$610	\$1,221	\$754	\$1,351
65+	\$606	\$1,381	\$719	\$1,449	65+	\$673	\$1,534	\$799	\$1,609	65+	\$740	\$1,687	\$878	\$1,770

**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.

<sup>1</sup>Risk adjustment factor

# DEDUCTIBLE PLANS WITH HRA PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

FEATURES	\$30/\$2,500 PLAN WITH HRA MEMBER PAYS	\$30/\$1,500 PLAN WITH HRA MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>1</sup></b> Individual/Family	\$2,500/\$5,000	\$1,500/\$3,000
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$250 for brand-name prescriptions	\$250 for brand-name prescriptions
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>2</sup></b> Self-only enrollment/Family enrollment	\$5,000/\$10,000	\$3,000/\$6,000
<b>IN THE MEDICAL OFFICE</b>		
Office visits	\$30 (after deductible)	\$30 (after deductible)
Preventive exams	\$30 <sup>3</sup>	\$30 <sup>3</sup>
Maternity/Prenatal care <sup>4</sup>	\$10 <sup>3</sup>	\$10 <sup>3</sup>
Well-child preventive care visits <sup>5</sup>	\$10 <sup>3</sup>	\$10 <sup>3</sup>
Vaccines (immunizations)	\$0 <sup>3</sup>	\$0 <sup>3</sup>
Allergy injections	\$0 <sup>3</sup>	\$0 <sup>3</sup>
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)
<b>EMERGENCY SERVICES</b>		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	\$150 (after deductible)	\$150 (after deductible)
<b>PRESCRIPTIONS<sup>6</sup></b>	(up to a 100-day supply)	(up to a 100-day supply)
Generic	\$10 <sup>3</sup>	\$10 <sup>3</sup>
Brand-name	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
<b>HOSPITAL CARE</b>		
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)
<b>MENTAL HEALTH SERVICES<sup>7</sup></b>		
In the medical office (up to 20 visits per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)
In the hospital (up to 30 days per calendar year)	20% per admission (after deductible)	20% per admission (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b>		
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)
<b>OTHER</b>		
Certain durable medical equipment (DME) <sup>8</sup>	Not covered	Not covered
Optical (eyewear)	Not covered <sup>9</sup>	Not covered <sup>9</sup>
Vision exam	\$30 <sup>3</sup>	\$30 <sup>3</sup>
Home health care (up to 100 two-hour visits per calendar year)	\$0 <sup>3</sup>	\$0 <sup>3</sup>
Hospice care	\$0 <sup>3</sup>	\$0 <sup>3</sup>

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

<sup>1</sup>Employer must fund at least 25 percent of the subscriber deductible for a \$1,500 deductible plan and at least 40 percent of the subscriber deductible for a \$2,500 deductible plan.

<sup>2</sup>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*).

<sup>3</sup>This service is not subject to a deductible.

<sup>4</sup>Scheduled prenatal visits and the first postpartum visit

<sup>5</sup>23 months or younger

<sup>6</sup>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.

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

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

<sup>9</sup>Kaiser Permanente members who are enrolled in this benefit plan 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](http://kp.org/2020) for Kaiser Permanente optical locations.

# DEDUCTIBLE PLANS WITH HRA RATE AREA 1

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>1</sup> .90					6 to 15 enrolling employees RAF <sup>1</sup> 1.00					5 or fewer enrolling employees RAF <sup>1</sup> 1.10				
<b>\$30/\$2,500 PLAN WITH HRA<sup>2</sup></b>														
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	\$117	\$321	\$265	\$387	<30	\$130	\$357	\$295	\$430	<30	\$143	\$392	\$324	\$473
30–39	\$139	\$371	\$280	\$434	30–39	\$154	\$412	\$311	\$482	30–39	\$169	\$452	\$342	\$529
40–49	\$188	\$383	\$294	\$487	40–49	\$208	\$425	\$326	\$540	40–49	\$229	\$468	\$358	\$595
50–54	\$250	\$520	\$343	\$576	50–54	\$278	\$577	\$381	\$639	50–54	\$306	\$635	\$419	\$703
55–59	\$311	\$647	\$403	\$709	55–59	\$345	\$718	\$447	\$787	55–59	\$380	\$790	\$493	\$866
60–64	\$398	\$797	\$492	\$882	60–64	\$443	\$886	\$548	\$980	60–64	\$487	\$975	\$602	\$1,079
65+	\$483	\$1,102	\$573	\$1,156	65+	\$537	\$1,224	\$637	\$1,284	65+	\$591	\$1,347	\$701	\$1,413
<b>\$30/\$1,500 PLAN WITH HRA<sup>2</sup></b>														
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	\$359	\$297	\$433	<30	\$146	\$399	\$330	\$481	<30	\$160	\$439	\$363	\$529
30–39	\$155	\$414	\$313	\$485	30–39	\$172	\$460	\$347	\$539	30–39	\$189	\$506	\$382	\$592
40–49	\$210	\$428	\$328	\$544	40–49	\$233	\$475	\$364	\$604	40–49	\$256	\$523	\$400	\$664
50–54	\$280	\$581	\$383	\$643	50–54	\$311	\$646	\$426	\$715	50–54	\$342	\$710	\$468	\$786
55–59	\$347	\$722	\$450	\$791	55–59	\$386	\$803	\$500	\$880	55–59	\$425	\$883	\$551	\$968
60–64	\$445	\$891	\$550	\$986	60–64	\$495	\$990	\$612	\$1,095	60–64	\$544	\$1,089	\$672	\$1,205
65+	\$540	\$1,231	\$641	\$1,291	65+	\$600	\$1,368	\$712	\$1,435	65+	\$660	\$1,505	\$783	\$1,579

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.

<sup>1</sup>Risk adjustment factor

<sup>2</sup>Rates do not include contributions to the HRA plan. Administrative fees apply.

# \$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)	Nonparticipating providers (out-of-network)
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE</b> Individual/Family	\$0		\$500/\$1,000 <sup>1</sup>
<b>PHARMACY CALENDAR-YEAR DEDUCTIBLE</b>	\$0	\$0	Not covered
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>2,3</sup></b> (calendar year)	\$3,000 individual \$6,000 family	\$3,000 individual \$9,000 family	\$6,000 individual \$18,000 family
<b>IN THE MEDICAL OFFICE</b>			
Office visits	\$35	\$45	50% <sup>4</sup>
Routine adult physical exams	\$35	\$45	Not covered
Adult preventive screening exam	\$35	\$45	50%
Maternity/Prenatal care <sup>5</sup>	\$0	\$25	50% <sup>6</sup>
Well-child preventive care visits	\$0 <sup>7</sup>	\$25 <sup>8</sup>	50% <sup>8</sup>
Vaccines (immunizations)	\$0	Not covered	Not covered
Allergy injections	\$5	\$25	50%
Infertility services	Not covered <sup>9</sup>	Not covered <sup>9</sup>	Not covered <sup>9</sup>
Occupational, physical, and speech therapy	\$35	\$45 <sup>6,10</sup>	50% <sup>10</sup>
Most labs and imaging	\$10	30%	50% <sup>6</sup>
MRI/CT/PET	\$50	30%	50% <sup>6</sup>
Outpatient surgery	\$100	30%	50% <sup>6</sup> (up to \$400 per procedure)
<b>EMERGENCY SERVICES</b>			
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		
<b>PRESCRIPTIONS</b> (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies) <sup>11</sup>	Obtained at participating MedImpact pharmacies <sup>12</sup>	
Generic	\$10	\$15	Not covered
Brand-name	\$35	\$35	Not covered
Nonformulary	\$40	\$40	Not covered
<b>HOSPITAL CARE</b>			
Physicians' services, room and board, tests, medications, supplies, therapies	\$200 per day	30% <sup>6</sup>	30% <sup>6</sup>
Skilled nursing facility care	\$0 <sup>13</sup>	30% <sup>6,10</sup>	30% <sup>6,10</sup>
<b>MENTAL HEALTH SERVICES<sup>14</sup></b>			
In the medical office (up to 20 visits per calendar year)	\$35 individual therapy \$17 group therapy	\$45 individual therapy Group therapy not covered	50% individual therapy Group therapy not covered
In the hospital (up to 30 days per calendar year)	\$200 per day	Not covered	Not covered
<b>CHEMICAL DEPENDENCY SERVICES</b>			
In the medical office (counseling for dependency; medical management of withdrawal symptoms)	\$35 individual therapy \$5 group therapy	Individual therapy not covered Group therapy not covered	Individual therapy not covered Group therapy not covered
In the hospital (medical management of withdrawal symptoms)	\$200 per day	Not covered	Not covered
<b>OTHER</b>			
Certain durable medical equipment (DME) <sup>15</sup> DME used during a covered stay in a Plan hospital or a skilled nursing facility	\$0	30% <sup>6,16</sup>	50% <sup>6,16</sup>
DME used in the home	Not covered	30% <sup>6,16</sup>	50% <sup>6,16</sup>
Optical (eyewear)	Not covered <sup>17</sup>	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% <sup>6,18</sup>	20% <sup>6,18</sup>
Hospice care	\$0	30% <sup>6,19</sup>	50% <sup>6,19</sup>

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

**Note:** For your group to be eligible for the \$35 POS plan or the PPO plans, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment 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 an HMO plan, and the combined enrollment in KPIC medical plans must not exceed 30 percent.

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

# \$35 POS PLAN RATE AREA 1

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>20</sup> .90					6 to 15 enrolling employees RAF <sup>20</sup> 1.00					5 or fewer enrolling employees RAF <sup>20</sup> 1.10				
\$35 POS PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$373	\$1,056	\$961	\$1,374	<30	\$414	\$1,173	\$1,068	\$1,527	<30	\$456	\$1,291	\$1,175	\$1,680
30–39	\$427	\$1,172	\$1,001	\$1,540	30–39	\$475	\$1,303	\$1,112	\$1,712	30–39	\$522	\$1,433	\$1,223	\$1,883
40–49	\$559	\$1,243	\$980	\$1,599	40–49	\$621	\$1,380	\$1,088	\$1,776	40–49	\$683	\$1,518	\$1,197	\$1,953
50–54	\$736	\$1,535	\$1,148	\$1,869	50–54	\$818	\$1,705	\$1,275	\$2,076	50–54	\$900	\$1,876	\$1,403	\$2,285
55–59	\$922	\$1,936	\$1,328	\$2,205	55–59	\$1,024	\$2,151	\$1,475	\$2,450	55–59	\$1,126	\$2,365	\$1,622	\$2,694
60–64	\$1,160	\$2,247	\$1,495	\$2,544	60–64	\$1,289	\$2,496	\$1,661	\$2,826	60–64	\$1,417	\$2,745	\$1,827	\$3,108
65+	\$1,403	\$3,093	\$1,863	\$3,229	65+	\$1,558	\$3,436	\$2,070	\$3,587	65+	\$1,714	\$3,779	\$2,277	\$3,945

<b>Employee/Dependent codes</b>	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.

- <sup>1</sup>Deductible amounts are combined for services provided by PHCS providers and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. Lifetime maximum is \$2 million combined for services provided by PHCS providers and nonparticipating providers.
- <sup>2</sup>The annual out-of-pocket maximum (OOPM) 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* and the *Certificate of Insurance*).
- <sup>3</sup>Covered charges incurred to satisfy the out-of-pocket maximum at the PHCS providers level will not be applicable toward satisfaction of the out-of-pocket maximum at the nonparticipating providers level. However, covered charges applied to satisfy the out-of-pocket maximum at the nonparticipating providers level will continue to be applicable toward satisfaction of the out-of-pocket maximum at the PHCS providers 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 or nonparticipating providers level. Covered charges at the PHCS 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.
- <sup>4</sup>Routine adult physicals are not covered.
- <sup>5</sup>Scheduled prenatal visits and the first postpartum visit
- <sup>6</sup>Based on maximum allowable charge
- <sup>7</sup>Covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger
- <sup>8</sup>Ages 0 to 18
- <sup>9</sup>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, option 2.
- <sup>10</sup>60-day limit per calendar year for services from PHCS and nonparticipating providers combined
- <sup>11</sup>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.
- <sup>12</sup>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.
- <sup>13</sup>Up to 100 days per benefit period
- <sup>14</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage* and the KPIC *Certificate of Insurance*.
- <sup>15</sup>Please refer to the *Evidence of Coverage* and the *Certificate of Insurance* for more information; most DME is not covered under the HMO (in-network) tier. DME is limited to a combined maximum of \$2,000 per calendar year for services provided by PHCS providers and nonparticipating providers.
- <sup>16</sup>\$2,000 maximum per calendar year for services from PHCS and nonparticipating providers combined
- <sup>17</sup>Kaiser Permanente members who are enrolled in this benefit plan 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](http://kp.org/2020) for Kaiser Permanente optical locations.
- <sup>18</sup>Home health care is limited to a maximum of 100 visits per calendar year combined for services provided by PHCS providers and nonparticipating providers. Deductible amount is limited to a maximum of \$50 per calendar year.
- <sup>19</sup>180-day limit per calendar year for services from PHCS and nonparticipating providers combined.
- <sup>20</sup>Risk adjustment factor

### HMO exclusions and limitations

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

# \$40/\$2,500 PPO INSURANCE PLAN WITH HSA OPTION **PLAN HIGHLIGHTS** EFFECTIVE 1/1/09–6/1/09

FEATURES	PHCS providers (PPO) <sup>1</sup>	Nonparticipating providers (out-of-network) <sup>1</sup>
	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>2</sup></b> Individual/Family	\$2,500/\$5,000	\$3,500/\$7,000
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>3</sup></b> Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
<b>MAXIMUM BENEFIT WHILE INSURED<sup>4</sup></b>	\$5 million	
<b>HOSPITAL CARE</b> 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% (up to \$600 per day) <sup>5</sup> 50% (up to \$600 per day) <sup>5</sup> 50% (up to \$600 per day) <sup>5</sup> 50% 50% (up to \$600 per day) <sup>5</sup>
<b>OUTPATIENT CARE</b> 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 <sup>10</sup> Diabetic day care management	\$40 copay <sup>6,7</sup> \$40 copay <sup>6,7,8</sup> \$40 copay <sup>6,7</sup> \$25 copay <sup>6,9</sup> \$40 copay <sup>6,7</sup> 30% 30% 30% \$40 copay <sup>6,7</sup> 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% <sup>7</sup> 50% <sup>9</sup> 50% 50% (up to \$400 per surgery) <sup>6</sup> 50% 50% 50% 50% 50% 50% Not covered Not covered 50%
<b>EMERGENCY SERVICES</b> Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service Nonemergency urgent care	\$100 copay, 50% (copay waived if admitted) 50% 50% 30%	\$100 copay, 50% (copay waived if admitted) 50% 50% 50%
<b>PRESCRIPTIONS<sup>12</sup></b> Generic drugs Brand-name drugs Self-administered injectable medications <sup>14</sup> Mail-order generic drugs Mail-order brand-name drugs	<b>MedImpact pharmacy<sup>13</sup></b> \$15 copay <sup>6</sup> (maximum 30-day supply) \$35 copay <sup>6</sup> (maximum 30-day supply) 30% <sup>6</sup> \$30 copay <sup>6</sup> (maximum 100-day supply) \$70 copay <sup>6</sup> (maximum 100-day supply)	<b>Non-MedImpact pharmacy</b> Not covered Not covered Not covered Not covered Not covered
<b>MENTAL HEALTH CARE</b> Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child <sup>15</sup> All other covered mental illness <sup>16</sup> Outpatient visits Severe mental illness and serious emotional disturbances of a child <sup>15</sup> All other covered mental illness <sup>17</sup>	30% 30% \$40 copay <sup>6,7</sup> 30%	50% (up to \$600 per day) <sup>5</sup> 50% (up to \$175 per day; 20 days maximum) 50% 50%
<b>ALCOHOL AND CHEMICAL DEPENDENCY<sup>18</sup></b> Inpatient hospitalization <sup>16</sup> Outpatient visits <sup>17</sup>	30% 30%	50% (up to \$175 per day) 50%
<b>ADDITIONAL BENEFITS</b> Care in a skilled nursing facility (60-day combined limit per calendar year) Home health care (100-day combined limit per calendar year) <sup>19</sup> Hospice care (180-day combined lifetime limit) Infertility services <sup>20</sup> Durable medical equipment (DME)/prosthetics, orthotics, and special footwear <sup>21</sup> Diabetic equipment and supplies <sup>22</sup>	30% 20% 30% 30% 30% 30%	50% 20% Not covered 50% 50% 30%

**Note:** For your group to be eligible for the \$35 POS Plan or the PPO plans, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment 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 an HMO plan, and the combined enrollment in KPIC medical plans must not exceed 30 percent.

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

# \$40/\$2,500 PPO INSURANCE PLAN WITH HSA RATE AREA 1

EFFECTIVE 1/1/09-6/1/09

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<sup>23</sup> .90

**6 to 15 enrolling employees**  
RAF<sup>23</sup> 1.00

**5 or fewer enrolling employees**  
RAF<sup>23</sup> 1.10

### \$40/\$2,500 PPO INSURANCE PLAN WITH HSA

Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$275	\$801	\$596	\$899	<30	\$306	\$891	\$662	\$1,000	<30	\$336	\$979	\$728	\$1,099
30-39	\$339	\$946	\$660	\$1,042	30-39	\$377	\$1,052	\$733	\$1,159	30-39	\$415	\$1,157	\$807	\$1,275
40-49	\$454	\$1,001	\$696	\$1,156	40-49	\$504	\$1,112	\$772	\$1,285	40-49	\$555	\$1,223	\$850	\$1,413
50-54	\$611	\$1,281	\$800	\$1,367	50-54	\$679	\$1,423	\$889	\$1,519	50-54	\$747	\$1,566	\$978	\$1,671
55-59	\$753	\$1,582	\$940	\$1,664	55-59	\$836	\$1,757	\$1,044	\$1,849	55-59	\$920	\$1,933	\$1,149	\$2,034
60-64	\$981	\$1,961	\$1,167	\$2,042	60-64	\$1,090	\$2,179	\$1,297	\$2,269	60-64	\$1,199	\$2,397	\$1,427	\$2,496
65+	\$1,220	\$2,845	\$1,405	\$2,920	65+	\$1,356	\$3,162	\$1,562	\$3,246	65+	\$1,491	\$3,477	\$1,717	\$3,569

<b>Employee/Dependent codes</b>	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.

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

<sup>1</sup>Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

<sup>2</sup>Medical calendar-year deductible amounts are combined for services provided by PHCS providers and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum.

<sup>3</sup>Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating providers tier will accumulate toward satisfaction of the out-of-pocket maximum on the PHCS providers tier. Covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating providers tier.

<sup>4</sup>Maximum benefit while insured is combined for services provided by PHCS providers and nonparticipating providers.

<sup>5</sup>\$600 per-day maximum is combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

<sup>6</sup>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.

<sup>7</sup>Exempt from deductibles

<sup>8</sup>Routine adult physical exams are limited to one exam every 12 months and \$400 per calendar year.

<sup>9</sup>Well-child preventive care is exempt from deductibles and includes immunizations.

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

<sup>11</sup>The PHCS provider 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.

<sup>12</sup>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.

<sup>13</sup>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.

<sup>14</sup>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.

<sup>15</sup>Severe mental illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

<sup>16</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both PHCS providers and nonparticipating providers.

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

<sup>18</sup>In addition to the specified day and visit limits noted, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by PHCS providers and nonparticipating providers.

<sup>19</sup>Combined maximum deductible of \$50 per calendar year

<sup>20</sup>Benefits payable for treatment of infertility are limited to \$1,000 per calendar year combined for services provided by PHCS providers or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

<sup>21</sup>DME is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS providers and nonparticipating providers.

<sup>22</sup>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.

<sup>23</sup>Risk adjustment factor

### Important notice

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.

# \$40/\$1,000 PPO INSURANCE PLAN PLAN HIGHLIGHTS

EFFECTIVE 1/1/09–6/1/09

FEATURES	PHCS providers (PPO) <sup>1</sup>	Nonparticipating providers (out-of-network) <sup>1</sup>
	MEMBER PAYS	MEMBER PAYS
<b>MEDICAL CALENDAR-YEAR DEDUCTIBLE<sup>2</sup></b> Individual/Family	\$1,000/\$2,000	
<b>ANNUAL OUT-OF-POCKET MAXIMUM<sup>3</sup></b> Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
<b>MAXIMUM BENEFIT WHILE INSURED<sup>4</sup></b>	\$5 million	
<b>HOSPITAL CARE</b> 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% (up to \$600 per day) <sup>5</sup> 50% (up to \$600 per day) <sup>5</sup> 50% (up to \$600 per day) <sup>5</sup> 50% 50% (up to \$600 per day) <sup>5</sup>
<b>OUTPATIENT CARE</b> 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 <sup>10</sup> Diabetic day care management	\$40 copay <sup>6,7</sup> \$40 copay <sup>6,7,8</sup> \$40 copay <sup>6,7</sup> \$25 copay <sup>6,9</sup> \$40 copay <sup>6,7</sup> 30% 30% 30% \$40 copay <sup>6,7</sup> 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% <sup>7</sup> 50% <sup>9</sup> 50% 50% (up to \$400 per surgery) <sup>6</sup> 50% 50% 50% 50% 50% Not covered Not covered 50% Not covered
<b>EMERGENCY SERVICES</b> Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service	\$100 (waived if admitted) Covered at the nonparticipating providers level Covered at the nonparticipating providers level <sup>11</sup>	\$100 (waived if admitted) 50% 50%
<b>PRESCRIPTIONS<sup>12</sup></b> Generic drugs Brand-name drugs deductible (pharmacy and mail order) Brand-name drugs Self-administered injectable medications <sup>14</sup> Mail-order generic drugs Mail-order brand-name drugs	<b>MedImpact pharmacy<sup>13</sup></b> \$15 copay <sup>6</sup> (maximum 30-day supply) \$200 deductible <sup>6</sup> \$35 copay <sup>6</sup> (maximum 30-day supply) 30% <sup>6</sup> \$30 copay <sup>6</sup> (maximum 100-day supply) \$70 copay <sup>6</sup> (maximum 100-day supply)	<b>Non-MedImpact pharmacy</b> Not covered Not covered Not covered Not covered Not covered Not covered
<b>MENTAL HEALTH CARE</b> Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child <sup>15</sup> All other covered mental illness <sup>16</sup> Outpatient visits Severe mental illness and serious emotional disturbances of a child <sup>15</sup> All other covered mental illness <sup>17</sup>	30% 30% 30% \$40 copay <sup>6,7</sup> 30%	50% (up to \$600 per day) <sup>5</sup> 50% (up to \$175 per day; 20 days maximum) 50% 50%
<b>ALCOHOL AND CHEMICAL DEPENDENCY<sup>18</sup></b> Inpatient hospitalization <sup>16</sup> Outpatient visits <sup>17</sup>	30% (20 days maximum) \$40 copay <sup>6</sup>	50% (up to \$175 per day; 20 days maximum) Not covered
<b>ADDITIONAL BENEFITS</b> Care in a skilled nursing facility (60-day combined limit per calendar year) Home health care (100-day combined limit per calendar year) <sup>19</sup> Hospice care (180-day combined lifetime limit) Infertility services <sup>20</sup> Durable medical equipment (DME)/prosthetics, orthotics, and special footwear <sup>21</sup> Diabetic equipment and supplies <sup>22</sup>	30% 20% 30% 30% 30% 30%	50% 20% 50% 50% 50% 30%

**Note:** For your group to be eligible for the \$35 POS Plan or the PPO plans, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment 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 an HMO plan, and the combined enrollment in KPIC medical plans must not exceed 30 percent.

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

EFFECTIVE 1/1/09–6/1/09

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

## Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF <sup>23</sup> .90					6 to 15 enrolling employees RAF <sup>23</sup> 1.00					5 or fewer enrolling employees RAF <sup>23</sup> 1.10				
\$40/\$1,000 PPO INSURANCE PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$297	\$866	\$644	\$972	<30	\$330	\$962	\$715	\$1,080	<30	\$363	\$1,059	\$787	\$1,189
30–39	\$367	\$1,024	\$714	\$1,128	30–39	\$407	\$1,137	\$792	\$1,253	30–39	\$448	\$1,251	\$872	\$1,378
40–49	\$491	\$1,082	\$752	\$1,250	40–49	\$545	\$1,202	\$835	\$1,389	40–49	\$600	\$1,322	\$919	\$1,527
50–54	\$660	\$1,384	\$864	\$1,477	50–54	\$734	\$1,539	\$961	\$1,642	50–54	\$807	\$1,692	\$1,057	\$1,806
55–59	\$814	\$1,710	\$1,016	\$1,799	55–59	\$904	\$1,899	\$1,129	\$1,998	55–59	\$995	\$2,090	\$1,242	\$2,199
60–64	\$1,060	\$2,120	\$1,262	\$2,207	60–64	\$1,178	\$2,355	\$1,402	\$2,452	60–64	\$1,296	\$2,591	\$1,542	\$2,697
65+	\$1,319	\$3,076	\$1,519	\$3,157	65+	\$1,466	\$3,418	\$1,689	\$3,509	65+	\$1,612	\$3,759	\$1,857	\$3,859

<b>Employee/Dependent codes</b>	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.

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

<sup>1</sup>Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

<sup>2</sup>Medical calendar-year deductible amounts are combined for services provided by PHCS providers and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum.

<sup>3</sup>Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating providers tier will accumulate toward satisfaction of the out-of-pocket maximum on the PHCS providers tier. Covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating providers tier.

<sup>4</sup>Maximum benefit while insured is combined for services provided by PHCS providers and nonparticipating providers.

<sup>5</sup>\$600 per-day maximum is combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

<sup>6</sup>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.

<sup>7</sup>Exempt from deductibles

<sup>8</sup>Routine adult physical exams are limited to one exam every 12 months and \$400 per calendar year.

<sup>9</sup>Well-child preventive care is exempt from deductibles and includes immunizations.

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

<sup>11</sup>The PHCS provider 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.

<sup>12</sup>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.

<sup>13</sup>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.

<sup>14</sup>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.

<sup>15</sup>Severe mental illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

<sup>16</sup>Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both PHCS providers and nonparticipating providers.

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

<sup>18</sup>In addition to the specified day and visit limits noted, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by PHCS providers and nonparticipating providers.

<sup>19</sup>Combined maximum deductible of \$50 per calendar year

<sup>20</sup>Benefits payable for treatment of infertility are limited to \$1,000 per calendar year combined for services provided by PHCS providers or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

<sup>21</sup>DME is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS providers and nonparticipating providers.

<sup>22</sup>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.

<sup>23</sup>Risk adjustment factor

# NOTES FOR POS AND PPO PLANS

## Precertification of services provided by PHCS 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 and nonparticipating providers exclusions and limitations

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

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## NOTES FOR ALL PLANS

HMO benefits are provided by Kaiser Foundation Health Plan, Inc., the nation's largest nonprofit health plan.

KPIC has contracted with PHCS to provide access to hospitals and physicians with a commitment to keeping out-of-pocket costs low through contracted rates.

The traditional HMO plan 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) underwrites the PHCS provider (PPO) plans and the out-of-network portion of the POS plans. KPIC is a subsidiary of KFHP.

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

**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*.

# RATE AREA 1

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 Mateo, and Santa Clara.

Portions of Contra Costa are also within Rate Area 1.

94002	94309	94850	95170
94005	94401-04	95002	95172-73
94010-11	94497	95008-09	95190-94
94013-28	94501-02	95011	95196
94030	94536-46	95013-15	
94035	94550-52	95020-21	
94037-44	94555	95026	
94060-66	94557	95030-33	
94070	94560	95035-38	
94074	94566	95042	
94080	94568	95044	
94083	94577-80	95046	
94085-89	94586-88	95050-56	
94101-12	94601-15	95070-71	
94114-47	94617-24	95101	
94150-52	94649	95103	
94155-56	94659-62	95106	
94158-64	94666	95108-13	
94172	94701-10	95115-36	
94177	94712	95138-41	
94188	94720	95148	
94199	94801-08	95150-61	
94301-06	94820	95164	

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