

PLAN HIGHLIGHTS AND RATES

Effective January to June 2008

2008 SMALL BUSINESS RATE AREA 6

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 benefits for certain available plans for small businesses.
- A full listing of all Kaiser Permanente plans and benefits can be found in the 2008 *Evidence of Coverage*.

CONTENTS

Copayment plans

2–3

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

Deductible plans

4–5

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

Health savings account (HSA) plans

6–7

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

Health reimbursement arrangement (HRA) plans

8–9

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.

\$35 POS Plan

10–11

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

\$40/\$1,000 PPO Plan

12–13

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

Rate Area 6 ZIP codes

15

COPAYMENT PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/08–6/1/08

FEATURES	MOST POPULAR COPAYMENT PLAN				
	\$50 PLAN MEMBER PAYS	\$30 PLAN MEMBER PAYS	\$20 PLAN MEMBER PAYS	\$15 PLAN MEMBER PAYS	\$5 PLAN MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	\$0	\$0	\$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM Self-only enrollment/Family enrollment	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$3,000/\$6,000	\$1,500/\$3,000
IN THE MEDICAL OFFICE					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive exams	\$50	\$30	\$20	\$15	\$5
Maternity/Prenatal care ²	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits ³	\$15	\$0	\$0	\$0	\$0
Vaccines (immunizations)	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$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
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
PRESCRIPTIONS⁴					
Generic	(up to a 100-day supply) \$10 ⁵	(up to a 100-day supply) \$10 ⁵	(up to a 30-day supply) \$10 ⁵	(up to a 30-day supply) \$10 ⁵	(up to a 100-day supply) \$5 ⁵
Brand-name	\$35 (after pharmacy deductible)	\$35 (after pharmacy deductible)	\$30 ⁵	\$25 ⁵	\$15 ⁵
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
Skilled nursing facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
MENTAL HEALTH SERVICES⁶					
In the medical office (up to 20 visits per calendar year)	\$50 individual \$25 group	\$30 individual \$15 group	\$20 individual \$10 group	\$15 individual \$7 group	\$5 individual \$2 group
In the hospital (up to 30 days per calendar year)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
CHEMICAL DEPENDENCY SERVICES					
In the medical office	\$50 individual	\$30 individual	\$20 individual	\$15 individual	\$5 individual
In the hospital (detoxification only)	\$500 per day	\$400 per day	\$300 per day	\$200 per day	\$0
OTHER					
Certain durable medical equipment (DME)	Not covered ⁷	Not covered ⁷	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered ⁸	Not covered ⁸	Not covered ⁸	\$150 allowance ⁹	\$150 allowance ⁹
Vision exam	\$50	\$30	\$20	\$15	\$5
Home health care (up to 100 two-hour visits per calendar year)	\$0	\$0	\$0	\$0	\$0
Hospice care	\$0	\$0	\$0	\$0	\$0

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

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

²Scheduled prenatal visits and the first postpartum visit

³23 months or younger

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

⁵This service is not subject to a deductible.

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

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

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

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

COPAYMENT PLANS RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$50 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$133	\$371	\$365	\$516	<30	\$147	\$411	\$405	\$572	<30	\$162	\$453	\$445	\$630
30–39	\$147	\$399	\$375	\$571	30–39	\$163	\$443	\$417	\$634	30–39	\$179	\$487	\$458	\$697
40–49	\$189	\$435	\$359	\$574	40–49	\$210	\$483	\$399	\$638	40–49	\$231	\$532	\$439	\$702
50–54	\$246	\$512	\$406	\$654	50–54	\$274	\$569	\$452	\$727	50–54	\$301	\$626	\$496	\$800
55–59	\$311	\$653	\$465	\$751	55–59	\$346	\$726	\$517	\$835	55–59	\$380	\$798	\$568	\$918
60–64	\$384	\$729	\$513	\$851	60–64	\$426	\$810	\$570	\$946	60–64	\$469	\$891	\$627	\$1,040
65+	\$435	\$940	\$654	\$1,033	65+	\$484	\$1,045	\$727	\$1,149	65+	\$532	\$1,150	\$800	\$1,264
\$30 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$144	\$403	\$396	\$561	<30	\$160	\$448	\$440	\$624	<30	\$177	\$494	\$485	\$687
30–39	\$160	\$434	\$408	\$621	30–39	\$177	\$481	\$453	\$689	30–39	\$195	\$530	\$499	\$759
40–49	\$206	\$474	\$391	\$625	40–49	\$229	\$527	\$435	\$695	40–49	\$252	\$579	\$478	\$764
50–54	\$268	\$557	\$442	\$712	50–54	\$298	\$619	\$491	\$791	50–54	\$328	\$681	\$541	\$870
55–59	\$339	\$712	\$507	\$819	55–59	\$376	\$790	\$562	\$909	55–59	\$414	\$869	\$619	\$1,000
60–64	\$418	\$794	\$559	\$927	60–64	\$464	\$881	\$621	\$1,029	60–64	\$511	\$970	\$683	\$1,132
65+	\$474	\$1,024	\$712	\$1,126	65+	\$526	\$1,137	\$791	\$1,250	65+	\$579	\$1,251	\$870	\$1,375
\$20 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$158	\$441	\$434	\$614	<30	\$175	\$489	\$481	\$681	<30	\$193	\$539	\$530	\$750
30–39	\$174	\$473	\$445	\$677	30–39	\$194	\$527	\$496	\$754	30–39	\$213	\$579	\$545	\$829
40–49	\$225	\$518	\$427	\$683	40–49	\$250	\$575	\$475	\$759	40–49	\$275	\$633	\$522	\$835
50–54	\$293	\$609	\$483	\$778	50–54	\$325	\$676	\$536	\$864	50–54	\$358	\$744	\$590	\$951
55–59	\$370	\$777	\$553	\$894	55–59	\$411	\$863	\$614	\$993	55–59	\$452	\$949	\$676	\$1,092
60–64	\$456	\$867	\$610	\$1,012	60–64	\$507	\$963	\$678	\$1,124	60–64	\$558	\$1,060	\$746	\$1,237
65+	\$518	\$1,119	\$779	\$1,230	65+	\$575	\$1,243	\$864	\$1,366	65+	\$633	\$1,367	\$951	\$1,503
\$15 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$177	\$494	\$486	\$687	<30	\$196	\$548	\$539	\$763	<30	\$216	\$603	\$593	\$839
30–39	\$195	\$530	\$499	\$759	30–39	\$217	\$590	\$555	\$844	30–39	\$239	\$649	\$610	\$929
40–49	\$252	\$580	\$479	\$765	40–49	\$280	\$644	\$532	\$850	40–49	\$308	\$709	\$585	\$936
50–54	\$328	\$682	\$541	\$872	50–54	\$364	\$757	\$601	\$968	50–54	\$401	\$833	\$661	\$1,065
55–59	\$414	\$870	\$619	\$1,001	55–59	\$461	\$968	\$689	\$1,113	55–59	\$507	\$1,064	\$758	\$1,224
60–64	\$511	\$971	\$683	\$1,134	60–64	\$568	\$1,079	\$760	\$1,260	60–64	\$625	\$1,187	\$836	\$1,386
65+	\$580	\$1,253	\$872	\$1,377	65+	\$644	\$1,392	\$968	\$1,530	65+	\$709	\$1,532	\$1,066	\$1,684
\$5 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$220	\$614	\$603	\$854	<30	\$244	\$681	\$670	\$948	<30	\$268	\$749	\$737	\$1,042
30–39	\$243	\$659	\$620	\$943	30–39	\$269	\$732	\$688	\$1,048	30–39	\$296	\$805	\$757	\$1,152
40–49	\$313	\$720	\$595	\$950	40–49	\$348	\$800	\$661	\$1,056	40–49	\$382	\$879	\$726	\$1,160
50–54	\$407	\$846	\$671	\$1,082	50–54	\$452	\$940	\$746	\$1,202	50–54	\$498	\$1,035	\$821	\$1,323
55–59	\$515	\$1,081	\$770	\$1,243	55–59	\$572	\$1,201	\$855	\$1,381	55–59	\$629	\$1,321	\$940	\$1,519
60–64	\$635	\$1,206	\$849	\$1,408	60–64	\$705	\$1,339	\$943	\$1,563	60–64	\$776	\$1,474	\$1,038	\$1,721
65+	\$720	\$1,556	\$1,082	\$1,711	65+	\$800	\$1,729	\$1,203	\$1,901	65+	\$880	\$1,902	\$1,323	\$2,091

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

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

¹Risk adjustment factor

DEDUCTIBLE PLANS PLAN HIGHLIGHTS

EFFECTIVE 1/1/08–6/1/08

FEATURES	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,000 PLAN MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$1,500/\$3,000	\$1,000/\$2,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM¹ Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE Office visits Preventive exams Maternity/prenatal care ³ Well-child preventive care visits ⁴ Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 ² \$30 ² \$0 ² \$0 ² \$0 ² \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) \$250 (after deductible)	\$30 ² \$30 ² \$0 ² \$0 ² \$0 ² \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) \$250 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$100 (after deductible) \$75 (after deductible)	\$100 (after deductible) \$75 (after deductible)
PRESCRIPTIONS⁵ Generic Brand-name	(up to a 100-day supply) \$10 ² \$35 (after \$250 pharmacy deductible)	(up to a 100-day supply) \$10 ² \$35 (after \$250 pharmacy deductible)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care	\$500 per day (after deductible) \$50 per day (after deductible) (up to 60 days per benefit period)	\$500 per day (after deductible) \$50 per day (after deductible) (up to 60 days per benefit period)
MENTAL HEALTH SERVICES⁶ 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) \$500 per day (after deductible)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) \$500 per day (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$30 (after deductible for individual therapy) \$500 per day (after deductible)	\$30 (after deductible for individual therapy) \$500 per day (after deductible)
OTHER Certain durable medical equipment (DME) ⁷ Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered ⁸ \$30 ² \$0 ² \$0 ²	Not covered Not covered ⁸ \$30 ² \$0 ²

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

Note: The \$30/\$1,500 Deductible Plan is only available if offered with at least one copay plan. This option is available to groups with two or more eligible employees. If the \$30/\$1,500 Deductible Plan is offered with two or more copay plans, regular multiple plan offering rules apply.

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

²This service is not subject to a deductible.

³Scheduled prenatal visits and the first postpartum visit

⁴23 months or younger

⁵Prescription 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.

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

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

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

DEDUCTIBLE PLANS RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
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\$30/\$1,500 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$91	\$248	\$205	\$299	<30	\$101	\$276	\$228	\$332	<30	\$111	\$303	\$251	\$365
30–39	\$107	\$286	\$216	\$335	30–39	\$119	\$318	\$240	\$372	30–39	\$131	\$350	\$264	\$410
40–49	\$145	\$296	\$227	\$376	40–49	\$161	\$328	\$252	\$417	40–49	\$177	\$361	\$277	\$459
50–54	\$193	\$401	\$264	\$444	50–54	\$215	\$446	\$294	\$494	50–54	\$236	\$490	\$323	\$542
55–59	\$240	\$499	\$311	\$547	55–59	\$266	\$554	\$345	\$607	55–59	\$293	\$609	\$380	\$668
60–64	\$307	\$615	\$380	\$680	60–64	\$341	\$683	\$422	\$756	60–64	\$376	\$752	\$465	\$832
65+	\$373	\$850	\$443	\$892	65+	\$414	\$944	\$491	\$990	65+	\$456	\$1,039	\$541	\$1,090

\$30/\$1,000 PLAN														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$109	\$299	\$247	\$360	<30	\$122	\$333	\$276	\$401	<30	\$134	\$366	\$303	\$441
30–39	\$129	\$345	\$261	\$404	30–39	\$144	\$384	\$290	\$449	30–39	\$158	\$422	\$319	\$494
40–49	\$175	\$357	\$274	\$453	40–49	\$194	\$396	\$304	\$503	40–49	\$214	\$436	\$334	\$554
50–54	\$233	\$484	\$319	\$536	50–54	\$259	\$538	\$355	\$596	50–54	\$285	\$592	\$390	\$655
55–59	\$290	\$603	\$376	\$661	55–59	\$322	\$670	\$417	\$734	55–59	\$354	\$736	\$459	\$807
60–64	\$371	\$743	\$459	\$822	60–64	\$413	\$826	\$510	\$914	60–64	\$454	\$908	\$561	\$1,005
65+	\$450	\$1,027	\$534	\$1,077	65+	\$500	\$1,141	\$593	\$1,197	65+	\$550	\$1,255	\$653	\$1,317

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

¹Risk adjustment factor

DEDUCTIBLE PLANS WITH HSA OPTION PLAN HIGHLIGHTS

EFFECTIVE 1/1/08–6/1/08

FEATURES	MOST POPULAR DEDUCTIBLE PLAN		
	\$30/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$1,500 PLAN WITH HSA MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$2,700/\$5,450 ¹	\$2,700/\$5,450 ¹	\$1,500/\$3,000 ²
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM³ Self-only enrollment/Family enrollment	\$5,250/\$10,500	\$2,700/\$5,450	\$1,500/\$3,000
IN THE MEDICAL OFFICE Office visits Preventive exams Maternity/Prenatal care ⁵ Well-child preventive care visits ⁶ Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 ⁴ \$10 ⁴ \$10 ⁴ \$0 ⁴ \$5 (after deductible) Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 30% (after deductible)	\$0 (after deductible) \$0 ⁴ \$0 ⁴ \$0 ⁴ \$0 ⁴ \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 ⁴ \$0 ⁴ \$0 ⁴ \$0 ⁴ \$0 (after deductible) Not covered \$0 (after deductible) \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	30% (after deductible) \$100 (after deductible)	\$0 (after deductible) \$0 (after deductible)	\$0 (after deductible) \$0 (after deductible)
PRESCRIPTIONS⁷ 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)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care (up to 100 days per benefit period)	30% per admission (after deductible) 30% per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)	\$0 per admission (after deductible) \$0 per admission (after deductible)
MENTAL HEALTH SERVICES⁸ In the medical office (up to 20 visits per calendar year) In the hospital (up to 30 days per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 (after deductible for group therapy) \$0 per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 30% per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)	\$0 (after deductible for individual therapy) \$0 per admission (after deductible)
OTHER Certain durable medical equipment (DME) ⁹ Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered ¹⁰ \$30 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered ¹⁰ \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)	Not covered Not covered ¹⁰ \$0 (after deductible) \$0 (after deductible) \$0 (after deductible)

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

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

²The entire family deductible must be met before copayments apply for individual family members.

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

⁴This service is not subject to a deductible.

⁵Scheduled prenatal visits and the first postpartum visit

⁶23 months or younger

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

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

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

¹⁰Kaiser 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.

DEDUCTIBLE PLANS WITH HSA OPTION RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$2,700 PLAN WITH HSA														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$64	\$176	\$145	\$212	<30	\$72	\$196	\$162	\$236	<30	\$79	\$216	\$178	\$260
30–39	\$76	\$203	\$153	\$238	30–39	\$84	\$225	\$170	\$264	30–39	\$93	\$248	\$188	\$290
40–49	\$103	\$210	\$161	\$267	40–49	\$114	\$233	\$178	\$296	40–49	\$126	\$257	\$197	\$326
50–54	\$137	\$285	\$188	\$316	50–54	\$153	\$317	\$209	\$351	50–54	\$168	\$349	\$230	\$386
55–59	\$171	\$355	\$222	\$389	55–59	\$189	\$394	\$245	\$432	55–59	\$208	\$433	\$270	\$475
60–64	\$219	\$438	\$271	\$485	60–64	\$243	\$486	\$300	\$538	60–64	\$267	\$534	\$330	\$591
65+	\$265	\$604	\$315	\$634	65+	\$295	\$672	\$350	\$705	65+	\$324	\$739	\$385	\$775
\$0/\$2,700 PLAN WITH HSA														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$73	\$200	\$165	\$241	<30	\$81	\$222	\$183	\$267	<30	\$89	\$244	\$201	\$294
30–39	\$86	\$230	\$174	\$269	30–39	\$95	\$255	\$192	\$299	30–39	\$105	\$281	\$212	\$329
40–49	\$116	\$237	\$182	\$301	40–49	\$129	\$263	\$202	\$334	40–49	\$142	\$290	\$222	\$368
50–54	\$155	\$322	\$212	\$356	50–54	\$172	\$358	\$236	\$396	50–54	\$190	\$394	\$260	\$436
55–59	\$193	\$401	\$250	\$440	55–59	\$214	\$445	\$277	\$488	55–59	\$236	\$490	\$306	\$537
60–64	\$247	\$494	\$305	\$547	60–64	\$274	\$549	\$339	\$607	60–64	\$302	\$604	\$373	\$668
65+	\$300	\$683	\$356	\$716	65+	\$333	\$759	\$395	\$796	65+	\$366	\$835	\$434	\$876
\$0/\$1,500 PLAN WITH HSA														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$85	\$233	\$192	\$281	<30	\$94	\$258	\$213	\$311	<30	\$104	\$284	\$235	\$342
30–39	\$100	\$268	\$202	\$314	30–39	\$111	\$297	\$225	\$348	30–39	\$123	\$328	\$248	\$384
40–49	\$136	\$277	\$213	\$352	40–49	\$151	\$308	\$236	\$391	40–49	\$166	\$339	\$260	\$431
50–54	\$181	\$376	\$248	\$416	50–54	\$201	\$418	\$275	\$463	50–54	\$221	\$459	\$303	\$508
55–59	\$225	\$468	\$292	\$513	55–59	\$250	\$520	\$324	\$570	55–59	\$275	\$572	\$357	\$627
60–64	\$288	\$577	\$356	\$638	60–64	\$320	\$641	\$396	\$709	60–64	\$352	\$705	\$435	\$780
65+	\$350	\$798	\$415	\$837	65+	\$389	\$886	\$462	\$929	65+	\$427	\$974	\$507	\$1,022

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

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

¹Risk adjustment factor

DEDUCTIBLE PLANS WITH HRA PLAN HIGHLIGHTS

EFFECTIVE 1/1/08–6/1/08

FEATURES	\$30/\$2,500 PLAN WITH HRA MEMBER PAYS	\$30/\$1,500 PLAN WITH HRA MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE¹ Individual/Family	\$2,500/\$5,000	\$1,500/\$3,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand-name prescriptions	\$250 for brand-name prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM² Self-only enrollment/Family enrollment	\$5,000/\$10,000	\$3,000/\$6,000
IN THE MEDICAL OFFICE Office visits Preventive exams Maternity/Prenatal care ⁴ Well-child preventive care visits ⁵ Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$30 (after deductible) \$30 ³ \$10 ³ \$10 ³ \$0 ³ \$0 ³ Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 20% (after deductible)	\$30 (after deductible) \$30 ³ \$10 ³ \$10 ³ \$0 ³ \$0 ³ Not covered \$30 (after deductible) \$10 (after deductible) \$50 (after deductible) 20% (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	20% (after deductible) \$150 (after deductible)	20% (after deductible) \$150 (after deductible)
PRESCRIPTIONS⁶ Generic Brand-name	(up to a 100-day supply) \$10 ³ \$35 (after \$250 pharmacy deductible)	(up to a 100-day supply) \$10 ³ \$35 (after \$250 pharmacy deductible)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care	20% per admission (after deductible) 20% per day (after deductible) (up to 100 days per benefit period)	20% per admission (after deductible) 20% per day (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES⁷ 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) 20% per admission (after deductible)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy) 20% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$30 (after deductible for individual therapy) 20% per admission (after deductible)	\$30 (after deductible for individual therapy) 20% per admission (after deductible)
OTHER Certain durable medical equipment (DME) ⁸ Optical (eyewear) Vision exam Home health care (up to 100 two-hour visits per calendar year) Hospice care	Not covered Not covered ⁹ \$30 ³ \$0 ³ \$0 ³	Not covered Not covered ⁹ \$30 ³ \$0 ³ \$0 ³

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

¹Employer must choose a funding level percentage—either 40%, 50%, or 60%—of the health plan deductible.

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

³This service is not subject to a deductible.

⁴Scheduled prenatal visits and the first postpartum visit

⁵23 months or younger

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

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

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

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

DEDUCTIBLE PLANS WITH HRA RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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

Monthly rates for groups new to Kaiser Permanente

16 to 50 enrolling employees RAF ¹ .90					6 to 15 enrolling employees RAF ¹ 1.00					5 or fewer enrolling employees RAF ¹ 1.10				
\$30/\$2,500 PLAN WITH HRA²														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$88	\$241	\$199	\$290	<30	\$98	\$268	\$222	\$323	<30	\$108	\$295	\$244	\$355
30–39	\$104	\$278	\$210	\$326	30–39	\$116	\$310	\$234	\$363	30–39	\$127	\$340	\$257	\$398
40–49	\$141	\$288	\$220	\$366	40–49	\$156	\$319	\$244	\$405	40–49	\$172	\$351	\$269	\$446
50–54	\$188	\$390	\$257	\$432	50–54	\$209	\$434	\$286	\$480	50–54	\$230	\$477	\$315	\$528
55–59	\$234	\$486	\$303	\$533	55–59	\$259	\$539	\$336	\$591	55–59	\$285	\$593	\$370	\$650
60–64	\$299	\$599	\$370	\$663	60–64	\$333	\$666	\$412	\$737	60–64	\$366	\$732	\$452	\$810
65+	\$363	\$828	\$431	\$869	65+	\$403	\$919	\$478	\$964	65+	\$444	\$1,012	\$527	\$1,062
\$30/\$1,500 PLAN WITH HRA²														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$99	\$270	\$223	\$325	<30	\$109	\$299	\$247	\$360	<30	\$120	\$329	\$272	\$397
30–39	\$116	\$311	\$235	\$364	30–39	\$129	\$345	\$261	\$404	30–39	\$142	\$380	\$287	\$445
40–49	\$157	\$321	\$246	\$408	40–49	\$175	\$357	\$274	\$454	40–49	\$192	\$392	\$301	\$498
50–54	\$210	\$436	\$288	\$483	50–54	\$234	\$485	\$320	\$537	50–54	\$257	\$533	\$352	\$590
55–59	\$261	\$543	\$338	\$595	55–59	\$290	\$603	\$376	\$661	55–59	\$319	\$663	\$414	\$727
60–64	\$334	\$669	\$413	\$740	60–64	\$372	\$744	\$460	\$823	60–64	\$409	\$818	\$505	\$905
65+	\$406	\$925	\$482	\$970	65+	\$451	\$1,028	\$535	\$1,078	65+	\$496	\$1,131	\$589	\$1,186

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

¹Risk adjustment factor

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

\$35 POS PLAN PLAN HIGHLIGHTS

EFFECTIVE 1/1/08–6/1/08

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network)	PHCS providers (PPO)	Nonparticipating providers (out-of-network)
	MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$0	\$500/\$1,000 ¹	
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$0	\$0	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM^{2,3} (calendar year)	\$3,000 individual \$6,000 family	\$3,000 individual \$9,000 family	\$6,000 individual \$18,000 family
IN THE MEDICAL OFFICE Office visits Preventive exams Maternity/Prenatal care ⁴ Well-child preventive care visits Vaccines (immunizations) Allergy injections Infertility services Occupational, physical, and speech therapy Most labs and imaging MRI/CT/PET Outpatient surgery	\$35 \$35 \$0 \$0 ⁶ \$0 \$5 Not covered ⁸ \$35 \$10 \$50 \$100	\$45 \$45 \$25 \$25 ⁷ Not covered \$25 Not covered ⁸ \$45 ⁵ (combined 60-day limit per calendar year) 30% 30% 30%	50% 50% 50% ⁵ 50% ⁷ Not covered 50% Not covered ⁸ 50% 50% ⁵ 50% ⁵ 50% ⁵
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$100 \$75	Emergency Department visits and ambulance for emergency medical conditions are covered as an HMO benefit for services received at any provider.	
PRESCRIPTIONS (up to a 100-day supply) Generic Brand-name Nonformulary	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies) ⁹ \$10 \$35 \$40	Obtained at participating MedImpact pharmacies ¹⁰ \$15 \$35 \$40	Not covered Not covered Not covered
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies Skilled nursing facility care	\$200 per day \$0 (up to 100 days per benefit period)	30% ⁵ 30% ⁵ (combined 60-day limit per calendar year)	30% ⁵ 30% ⁵
MENTAL HEALTH SERVICES¹¹ In the medical office (up to 20 visits per calendar year) In the hospital (up to 30 days per calendar year)	\$35 individual therapy \$17 group therapy \$200 per day	\$45 individual therapy Group therapy not covered Not covered	50% individual therapy Group therapy not covered Not covered
CHEMICAL DEPENDENCY SERVICES In the medical office (counseling for dependency; medical management of withdrawal symptoms) In the hospital (medical management of withdrawal symptoms)	\$35 individual therapy \$5 group therapy \$200 per day	Individual therapy not covered Group therapy not covered Not covered	Individual therapy not covered Group therapy not covered Not covered
OTHER Certain durable medical equipment (DME) ¹² DME used during a covered stay in a Plan hospital or a skilled nursing facility DME used in the home Optical (eyewear) Vision exam Home health care Hospice care	\$0 Not covered Not covered ¹³ \$35 \$0 (up to 100 two-hour visits per calendar year) \$0	30% ⁵ (combined \$2,000 maximum per calendar year) 30% ⁵ (combined \$2,000 maximum per calendar year) Not covered Not covered 20% ^{5,14} 30% ⁵ (combined 180-day limit per calendar year)	50% ⁵ 50% ⁵ Not covered Not covered 20% ^{5,14} 50% ⁵

Note: For your group to be eligible for the \$35 POS Plan or the \$40/\$1,000 PPO Plan, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment plan as part of a multiple plan offering. If you include the 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 14.

\$35 POS PLAN RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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 ¹⁵ .90					6 to 15 enrolling employees RAF ¹⁵ 1.00					5 or fewer enrolling employees RAF ¹⁵ 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	\$240	\$679	\$618	\$884	<30	\$266	\$754	\$686	\$982	<30	\$293	\$830	\$755	\$1,080
30–39	\$275	\$754	\$644	\$991	30–39	\$305	\$837	\$715	\$1,100	30–39	\$336	\$922	\$787	\$1,211
40–49	\$359	\$799	\$629	\$1,028	40–49	\$399	\$887	\$700	\$1,141	40–49	\$439	\$976	\$770	\$1,256
50–54	\$473	\$987	\$738	\$1,202	50–54	\$526	\$1,097	\$820	\$1,336	50–54	\$579	\$1,207	\$903	\$1,470
55–59	\$593	\$1,245	\$854	\$1,418	55–59	\$659	\$1,384	\$949	\$1,576	55–59	\$724	\$1,521	\$1,043	\$1,733
60–64	\$746	\$1,445	\$962	\$1,636	60–64	\$829	\$1,605	\$1,068	\$1,817	60–64	\$912	\$1,766	\$1,175	\$2,000
65+	\$902	\$1,989	\$1,198	\$2,076	65+	\$1,002	\$2,209	\$1,331	\$2,306	65+	\$1,102	\$2,430	\$1,464	\$2,537

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

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

¹Deductible 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.

²The 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*).

³Covered 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.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Based on maximum allowable charge

⁶Covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger

⁷Ages 0 to 18

⁸In accordance with California law, health care plans and insurers are required to offer contract holders and policyholders the option to purchase coverage of infertility treatment (excluding in vitro fertilization). For details regarding this optional coverage, including how you may elect this coverage and the amount of additional rates, please contact your broker or the Account Management Team at 1-800-790-4661, option 2.

⁹A 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.

¹⁰Participating 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.

¹¹Visit 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*.

¹²Please 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.

¹³Kaiser 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.

¹⁴Home 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.

¹⁵Risk adjustment factor

HMO exclusions and limitations

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

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

EFFECTIVE 1/1/08–6/1/08

PHCS providers
(PPO)¹

Nonparticipating providers
(out-of-network)¹

FEATURES	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE² Individual/Family	\$1,000/\$2,000	
ANNUAL OUT-OF-POCKET MAXIMUM³ Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000
MAXIMUM BENEFIT WHILE INSURED⁴	\$2 million	
HOSPITAL CARE Room, board, and critical care units Imaging, including X-rays and lab tests Transplants Physician, surgeon, and surgical services Nursing care, anesthesia, and inpatient prescribed drugs	30% 30% 30% 30% 30%	50% (up to \$600 per day) ⁵ 50% (up to \$600 per day) ⁵ 50% (up to \$600 per day) ⁵ 50% 50% (up to \$600 per day) ⁵
OUTPATIENT CARE Physician office visits Routine adult physical exams Adult preventive screening exam Well-child preventive care visits (through age 18) Pediatric visits Outpatient surgery Allergy testing visits Allergy injection visits Gynecological visits Maternity/Scheduled prenatal care and first postpartum visit Imaging, including X-rays Lab tests Eye exams for eyeglass prescriptions Hearing exams Occupational, physical, respiratory, and speech therapy visits ¹⁰ Diabetic day care management	\$40 copay ^{6,7} \$40 copay ^{6,7,8} \$40 copay ^{6,7} \$25 copay ^{6,9} \$40 copay ^{6,7} 30% 30% 30% \$40 copay ^{6,7} 30% 30% 30% Not covered Not covered 30% 30%	50% Not covered 50% ⁷ 50% ⁹ 50% 50% (up to \$400 per surgery) ⁶ 50% 50% 50% 50% 50% 50% Not covered Not covered Not covered 50% Not covered
EMERGENCY SERVICES Emergency Department visits Emergency ambulance service Medically necessary nonemergency ambulance service	\$100 (waived if admitted) Covered at the nonparticipating providers level Covered at the nonparticipating providers level ¹¹	\$100 (waived if admitted) 50% 50%
PRESCRIPTIONS¹² Generic drugs Brand-name drugs deductible (pharmacy and mail order) Brand-name drugs Self-administered injectable medications ¹⁴ Mail-order generic drugs Mail-order brand-name drugs	MedImpact pharmacy¹³ \$15 copay ⁶ (maximum 30-day supply) \$200 deductible ⁶ \$35 copay ⁶ (maximum 30-day supply) \$30 ⁶ \$30 copay ⁶ (maximum 100-day supply) \$70 copay ⁶ (maximum 100-day supply)	Non-MedImpact pharmacy Not covered Not covered Not covered Not covered Not covered Not covered
MENTAL HEALTH CARE Inpatient hospitalization Severe mental illness and serious emotional disturbances of a child ¹⁵ All other covered mental illness ¹⁶ Outpatient visits Severe mental illness and serious emotional disturbances of a child ¹⁵ All other covered mental illness ¹⁷	30% 30% 30% \$40 copay ^{6,7} 30%	50% (up to \$600 per day) ⁵ 50% (up to \$175 per day; 20 days maximum) 50% 50%
ALCOHOL AND CHEMICAL DEPENDENCY¹⁸ Inpatient hospitalization ¹⁶ Outpatient visits ¹⁷	30% (20 days maximum) \$40 copay ⁶	50% (up to \$175 per day; 20 days maximum) Not covered
ADDITIONAL BENEFITS Care in a skilled nursing facility (60-day combined limit per calendar year) Home health care (100-day combined limit per calendar year) ¹⁹ Hospice care (180-day combined lifetime limit) Infertility services ²⁰ Durable medical equipment/prosthetics, orthotics, and special footwear ²¹ Diabetic equipment and supplies ²²	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 \$40/\$1,000 PPO Plan, 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 the 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 14.

\$40/\$1,000 PPO PLAN RATE AREA 6

EFFECTIVE 1/1/08–6/1/08

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 ²³ .90					6 to 15 enrolling employees RAF ²³ 1.00					5 or fewer enrolling employees RAF ²³ 1.10				
\$40/\$1,000 PPO 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	\$253	\$737	\$548	\$827	<30	\$281	\$819	\$608	\$919	<30	\$309	\$901	\$669	\$1,011
30–39	\$312	\$870	\$607	\$959	30–39	\$346	\$967	\$673	\$1,065	30–39	\$381	\$1,064	\$741	\$1,172
40–49	\$417	\$920	\$639	\$1,063	40–49	\$464	\$1,023	\$711	\$1,182	40–49	\$510	\$1,124	\$781	\$1,299
50–54	\$562	\$1,178	\$736	\$1,257	50–54	\$624	\$1,308	\$817	\$1,396	50–54	\$686	\$1,439	\$898	\$1,536
55–59	\$692	\$1,454	\$864	\$1,530	55–59	\$769	\$1,615	\$960	\$1,699	55–59	\$846	\$1,777	\$1,056	\$1,870
60–64	\$902	\$1,803	\$1,073	\$1,877	60–64	\$1,002	\$2,003	\$1,192	\$2,085	60–64	\$1,102	\$2,203	\$1,311	\$2,294
65+	\$1,122	\$2,616	\$1,292	\$2,685	65+	\$1,246	\$2,906	\$1,435	\$2,983	65+	\$1,371	\$3,197	\$1,579	\$3,282

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

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

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

- ¹Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.
- ²Medical calendar-year deductible amounts are combined for services provided by PHCS providers and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum.
- ³Covered 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.
- ⁴Maximum benefit while insured is combined for services provided by PHCS providers and nonparticipating providers.
- ⁵\$600 per-day maximum is combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.
- ⁶Brand-name drug deductible, copayments, and coinsurance paid for physician office visit or paid for prescriptions filled at participating pharmacies are not subject to, nor do they contribute toward, satisfaction of either the calendar-year deductible or the out-of-pocket maximum.
- ⁷Exempt from deductibles
- ⁸Routine adult physical exams are limited to one exam every 24 months and \$400 per calendar year.
- ⁹Well-child preventive care is exempt from deductibles and includes immunizations.
- ¹⁰All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS providers and nonparticipating providers.
- ¹¹The 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.
- ¹²Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the patient requests a brand-name drug and a generic version is available.
- ¹³MedImpact pharmacy copayments are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the out-of-pocket maximum. Select prescription drugs are excluded from coverage.
- ¹⁴Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.
- ¹⁵Severe mental illness is limited to the following: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- ¹⁶Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 inpatient days per calendar year combined for both PHCS providers and nonparticipating providers.
- ¹⁷Benefits for treatment of other covered mental illnesses and alcohol and drug dependency are limited to 20 outpatient visits per calendar year.
- ¹⁸In addition to the specified day and visit limits noted, benefits payable for treatment of alcohol and drug dependency are subject to a combined limit of \$10,000 per calendar year and \$25,000 lifetime for services provided by PHCS providers and nonparticipating providers.
- ¹⁹Combined maximum deductible of \$50 per calendar year
- ²⁰Benefits payable for treatment of infertility are limited to \$1,000 per calendar year combined for services provided by PHCS 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.
- ²¹Durable medical equipment is limited to a maximum of \$2,000 per calendar year combined for services provided by PHCS providers and nonparticipating providers.
- ²²Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of \$2,000 per calendar year.
- ²³Risk 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

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) plan and the out-of-network portion of the POS plan. 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 6

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

Portions of Orange County are within Rate Area 6.

90620-24	92623-30	92728	92840-46
90630-33	92637	92735	92850
90680	92646-63	92780-82	92856-57
90720-21	92672-79	92799	92859
90740	92683-85	92801-09	92861-71
90742-43	92688	92811-12	92885-87
92602-07	92690-94	92814-17	92899
92609-10	92697-98	92821-23	
92612	92701-12	92825	
92614-20	92725	92831-38	

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