

Rates and Benefits for 2003

Added Choice for Small Business – Northern California Area

NEW GROUPS ONLY
Effective 10/1/03 – 12/1/03

If your employee selects the Traditional HMO option, the benefits are as follows:		If your employee selects the Point-of-Service option, the benefits are as follows:		
Features	Member Pays	Kaiser Permanente Plan Providers (HMO) Member Pays	CCN Providers* Member Pays	Any Other Providers* Member Pays
Calendar Year Deductible Individual/Family	\$0	\$0	\$500 ¹ /\$1,000 ¹	
Out-of-Pocket Maximum	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$2,500 individual ² \$7,500 family ²	\$5,000 individual ² \$15,000 family ²
In the Medical Office[†]				
Office visits	\$15	\$20	20%	40%
Physical, vision, and hearing exams	\$15	\$20	Not covered	Not covered
Women's preventive screening exam	\$15	\$20	20% ³	40% ³
Maternity/prenatal care ⁴	\$0	\$0	20%	40%
Well-child preventive care visits ⁵	\$0	\$0	Not covered	Not covered
Immunizations	\$0	\$0	Not covered	Not covered
Allergy injections	\$0	\$0	Not covered	Not covered
Infertility services	50%	50%	20% ⁶	40% ⁶
Occupational, physical, respiratory, and speech therapy	\$15	\$20	20% ⁷	40% ⁷
Lab, imaging, and other tests	\$0	\$0	20%	40%
Outpatient surgery	\$50	\$50	20%	40%
Emergency Services				
Emergency care provided in an emergency department from any provider (waived if admitted directly to hospital)	\$100 (copay waived if admitted directly to hospital)	Provided as an HMO benefit, subject to a \$100 copay, regardless of facility/hospital accessed. (copay waived if admitted directly to hospital)		
Ambulance	\$75	\$75	Not available ⁸	40% ⁸
Prescriptions (up to a 100-day supply)	Kaiser Permanente Plan pharmacy (including affiliated pharmacies) ⁹	Kaiser Permanente Plan pharmacy (including affiliated pharmacies) ⁹	Participating Pharmacy ¹⁰	Any Other Pharmacy ¹¹
Generic	\$10	\$10	\$15	\$25
Brand	\$25	\$30	\$35	\$40
Non-formulary	N/A	\$40 ¹²	\$40	\$40
Hospital Care[†]				
Physicians' services, room and board, tests, medications, supplies, therapies	\$100 per day (\$500 maximum per admission)	\$100 per day (\$500 maximum per admission)	20%	40%
Skilled nursing care	\$0 (100-day limit per benefit period)	\$0 (100-day limit per benefit period)	20% (Combined 60-day limit per Calendar Year)	40%
Home health care	\$0	\$0	20% ¹³	20% ¹³
Hospice care	\$0	\$0	20% (Combined 180-day limit per Calendar Year)	40%
Mental Health^{**†}				
In the Medical Office (20 visits per calendar year maximum)	\$15	\$20	Not covered	Not covered
In the Hospital (30 days per calendar year maximum)	\$100 per day (\$500 maximum per admission)	\$100 per day (\$500 maximum per admission)	Not covered	Not covered
Alcoholism and Drug Dependency Care[†]				
In the Medical Office (counseling for dependency; medical management of withdrawal symptoms)	\$15 individual \$5 group therapy	\$20 individual \$5 group therapy	Not covered	Not covered
In the Hospital (medical management of withdrawal symptoms)	\$100 per day (\$500 maximum per admission)	\$100 per day (\$500 maximum per admission)	Not covered	Not covered
Durable Medical Equipment (DME)				
DME used during a covered stay in a Plan Hospital or a Skilled Nursing Facility	\$0	\$0	30% ¹⁴	50% ¹⁴
DME used in the home	20%	20%	30% ¹⁴	50% ¹⁴
Optical (eyewear)				
Vision exam	\$150 allowance*** \$15	Not covered \$20	Not covered Not covered	Not covered Not covered

Dependents are covered to age 19; students are eligible as dependents to age 24.

* Based on Maximum Allowable Charge ** Visit or day limits do not apply to certain mental health care described in the *Evidence of Coverage*.

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

This brochure provides only a brief summary of the coverage available under the Policy. For a complete understanding of the terms of coverage, please read this brochure in conjunction with the Added Choice for Small Business *Evidence of Coverage* and the Kaiser Permanente Insurance Company *Certificate of Insurance*.

Monthly rates for groups new to Kaiser Permanente are as follows:

New groups with five or fewer subscribers are rated at R.A.F. 1.10. For new groups with six or more enrolling employees, final rates are contingent upon actual enrollment and review of applications, including health questionnaires. The final rates may be higher or lower, based on health questionnaires and demographic information.

R.A.F.♦ 1.0

Traditional HMO Option				
Age	EE only	EE+S	EE+C	EE+S+C
< 30	\$173	\$435	\$432	\$605
30 – 39	\$191	\$467	\$439	\$668
40 – 49	\$222	\$510	\$421	\$673
50 – 54	\$288	\$599	\$491	\$782
55 – 59	\$365	\$766	\$565	\$913
60 – 64	\$450	\$854	\$602	\$997
65+	\$534	\$1,136	\$766	\$1,211

Point-of-Service Option				
Age	EE only	EE+S	EE+C	EE+S+C
< 30	\$246	\$640	\$615	\$873
30 – 39	\$272	\$661	\$626	\$952
40 – 49	\$316	\$727	\$655	\$1,001
50 – 54	\$434	\$957	\$812	\$1,293
55 – 59	\$530	\$1,171	\$932	\$1,510
60 – 64	\$641	\$1,337	\$1,015	\$1,678
65+	\$784	\$1,725	\$1,168	\$1,890

R.A.F.♦ 1.10

Traditional HMO Option				
Age	EE only	EE+S	EE+C	EE+S+C
< 30	\$190	\$478	\$475	\$665
30 – 39	\$210	\$513	\$483	\$735
40 – 49	\$244	\$561	\$463	\$740
50 – 54	\$317	\$659	\$540	\$860
55 – 59	\$401	\$842	\$621	\$1,004
60 – 64	\$495	\$940	\$662	\$1,097
65+	\$588	\$1,250	\$843	\$1,333

Point-of-Service Option				
Age	EE only	EE+S	EE+C	EE+S+C
< 30	\$271	\$704	\$677	\$961
30 – 39	\$299	\$727	\$688	\$1,047
40 – 49	\$348	\$800	\$721	\$1,101
50 – 54	\$477	\$1,052	\$893	\$1,422
55 – 59	\$582	\$1,287	\$1,025	\$1,660
60 – 64	\$705	\$1,470	\$1,117	\$1,845
65+	\$862	\$1,897	\$1,284	\$2,079

Rates listed are for new Kaiser Permanente contracted employer groups with at least 2 and no more than 50 full-time (at least 30 hours per week) worldwide employees for at least 50% of the previous calendar quarter or previous calendar year from the effective date. Rates are not applicable to groups currently enrolled with Kaiser Permanente.

♦ Risk Adjustment Factor

Employee/Dependent Codes

EE = 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

Footnotes

- 1 Deductible amounts are combined for services provided by CCN Providers and Any Other Providers. Deductibles do not count toward satisfying the Out-of-Pocket Maximum. Lifetime maximum is \$2,000,000 combined for services provided by CCN Providers and Any Other Providers.
- 2 Covered Charges incurred to satisfy the Out-of-Pocket Maximum at the Participating Provider level will not be applicable towards satisfaction of the Out-of-Pocket Maximum at the Any Other Provider level. However, Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Any Other Provider level will continue to be applicable towards satisfaction of the Out-of-Pocket Maximum at the Participating Provider level.
- 3 Exempt from deductibles.
- 4 Scheduled prenatal visits and first postpartum visit.
- 5 Covered by HMO only to age 23 months or younger.
- 6 Benefits payable for treatment of infertility are limited to \$1,000 per Calendar Year combined for services provided by CCN Providers or Any Other Providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.
- 7 All outpatient therapies are limited to 60 visits per Calendar Year combined for both CCN Providers and Any Other Providers.
- 8 The CCN Provider Network does not contract for ambulance coverage. Therefore, ambulance coverage is payable at the Any Other Providers level. Ambulance coverage is limited to a maximum of \$2,000 per Calendar Year for all KPIC covered services.
- 9 Prescription drugs for the treatment of infertility are covered at 50% of charges at Kaiser Permanente Plan Pharmacies only.
- 10 Participating Pharmacy copayments and deductibles are not subject to, nor do they contribute towards satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription medications are excluded from Out-of-Network Coverage. Participating Pharmacies are Albertsons, Kmart, Longs, Raleys, RiteAid, Safeway, Sav-on, Vons, and Walgreens (except certain RiteAid and Sav-on locations in Stanislaus, which are designated as Affiliated Pharmacies). Please refer to *Your Guidebook to Kaiser Permanente Services* for more information regarding Participating Pharmacies in Coachella Valley and western Ventura County.
- 11 Prescriptions filled at non-participating pharmacies are subject to the noted per prescription deductible. Deductibles paid for prescriptions filled at non-participating pharmacies are not subject to, nor do they contribute towards satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from Coverage of CCN Providers and Any Other Providers.
- 12 Non-formulary prescription drugs are covered by Kaiser Permanente Insurance Company (KPIC).
- 13 Home health care is limited to a maximum of 100 visits per Calendar Year combined for services provided by CCN Providers and Any Other Providers. Deductible amount is limited to a maximum of \$50 per Calendar Year.
- 14 Durable Medical Equipment/Orthotics, Prosthetics and Special Footwear benefit is limited to a maximum of \$2,000 per Calendar Year combined for services provided by CCN Providers and Any Other Providers.

†Precertification of Services Provided by CCN Providers and Any Other Providers

Precertification is required for all hospital confinements, including preadmission testing, inpatient care at a skilled nursing facility or other licensed, free-standing 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.

CCN Providers' and Any Other 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 KFHP; 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 non-emergency 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 KPIC 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; craniomandibular or temporomandibular joint disorders, unless for medically necessary surgical treatment of the disorder; musculoskeletal therapy; weight management; 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 a Kaiser Permanente Small Business Representative at **1-800-730-4661**.

Topics include:

1. Factors that affect rate setting and rate adjustments.
2. Provisions related to renewing coverage.
3. Plan designs and premiums available to small groups.
4. Geographic areas covered by the Health Plan.

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

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

CCN Providers and Any Other Providers benefits under the Point-of-Service option are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of Kaiser Foundation Health Plan, Inc.

KPIC contracts with **CCN**, the administrator of the Participating Provider Network. Together they are dedicated to delivering competitively priced quality health care for small businesses.

