

FOR OUR SMALL BUSINESS GROUPS

Effective July-December 2005

Rate Area 5

Plan Highlights and Rates

2005 SMALL BUSINESS

For New Groups

Multiple Plan Offerings

Let your employees choose the best fit for them

Your company wouldn't run well if you didn't value the differences among individuals. Your employees are all individual, and they deserve the benefits that come when they can choose the health plan that best suits their and their families' unique needs. **Now, with Kaiser Permanente, you can offer a selection of deductible and copayment plans for your employees, at no added expense or effort to you.**

It's a business benefit, too

You need a simple solution, one that provides choice at the right price and is easy to administer. The problem is solved by providing a suite of plans from Kaiser Permanente.*

- **Easy!** Easier health plan decision-making, so you can get on with business.
- **Satisfied employees!** Relax, because your employees can select the plan that best fulfills their health and lifestyle needs.
- **Simple!** With transparent billing and administration—one application form, one monthly bill.
- **Affordable!** Defined employer contribution to meet your company's budget.

COPAYMENT PLANS

- \$5 Copayment Plan
- \$15 Copayment Plan
- \$20 Copayment Plan
- \$30 Copayment Plan
- \$50 Copayment Plan

DEDUCTIBLE PLANS

- \$10/1,000 Deductible Plan
- \$20/1,000 Deductible Plan
- \$30/1,000 Deductible Plan

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FOR OUR SMALL BUSINESS GROUPS

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Deductible Plans **PLAN HIGHLIGHTS**

FEATURES	\$30/\$1,000 PLAN MEMBER PAYS	\$20/\$1,000 PLAN MEMBER PAYS	\$10/\$1,000 PLAN MEMBER PAYS
MEDICAL CALENDAR YEAR DEDUCTIBLE			
Individual/Family	\$1,000/\$2,000	\$1,000/\$2,000	\$1,000/\$2,000
PHARMACY CALENDAR YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions	\$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM[§]			
Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000	\$3,500/\$7,000
IN THE MEDICAL OFFICE			
Office visits	\$30 after deductible	\$20 after deductible	\$10 after deductible
Preventive physical, vision, and hearing exams	\$30 [♦]	\$20 [♦]	\$10 [♦]
Maternity/prenatal care*	\$0 [♦]	\$0 [♦]	\$0 [♦]
Well-child preventive care visits**	\$0 [♦]	\$0 [♦]	\$0 [♦]
Immunizations	\$0 [♦]	\$0 [♦]	\$0 [♦]
Allergy injections	\$5 after deductible	\$5 after deductible	\$0 after deductible
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$30 after deductible	\$20 after deductible	\$10 after deductible
Lab and imaging	\$10 after deductible	\$10 after deductible	\$10 after deductible
MRI/CT/PET	\$50 after deductible	\$50 after deductible	\$50 after deductible
Outpatient surgery	\$100 after deductible	\$50 after deductible	\$50 after deductible
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	\$100 after deductible	\$100 after deductible	\$100 after deductible
Ambulance	\$75 after deductible	\$75 after deductible	\$75 after deductible
PRESCRIPTIONS***	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 100-day supply)
Generic	\$10 [♦]	\$10 [♦]	\$10 [♦]
Brand	\$35 after Pharmacy deductible	\$35 after Pharmacy deductible	\$35 after Pharmacy deductible
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day after deductible	\$100 per day after deductible	\$100 per day after deductible
Skilled Nursing Facility care	\$50 per day after deductible (up to 60 days per benefit period)	\$0 (up to 100 days per benefit period)	\$0 (up to 100 days per benefit period)
MENTAL HEALTH SERVICES****			
In the medical office (up to 20 visits per Calendar Year)	\$30 after deductible for individual \$15 after deductible for group therapy	\$20 after deductible for individual \$10 after deductible for group therapy	\$10 after deductible for individual \$5 after deductible for group therapy
In the hospital (up to 30 days per Calendar Year)	\$500 per day after deductible	\$100 per day after deductible	\$100 per day after deductible
CHEMICAL DEPENDENCY SERVICES			
In the medical office	\$30 after deductible for individual	\$20 after deductible for individual	\$10 after deductible for individual
In the hospital (detoxification only)	\$500 per day after deductible	\$100 per day after deductible	\$100 per day after deductible
OTHER			
Durable Medical Equipment (DME) DME used in the home in accord with our DME formulary	30% (\$2,000 maximum) [♦]	20% (\$2,000 maximum) [♦]	20% (\$2,000 maximum) [♦]
Optical (eyewear)	Not covered	Not covered	Not covered
Vision exam	\$30 [♦]	\$20 [♦]	\$10 [♦]
Home health care (up to 100 two-hour visits per Calendar Year)	\$0 [♦]	\$0 [♦]	\$0 [♦]
Hospice care	\$0 [♦]	\$0 [♦]	\$0 [♦]

[§] 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*).

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

* Scheduled prenatal visits and the first postpartum visit.

** 23 months or younger.

*** Prescription drugs 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.

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

This chart is a summary only. Additional information is provided in the Group's *Evidence of Coverage*.

RATE AREA 5

Deductible Plans

RATES

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

- New groups with **6 to 50** enrolling employees are rated at R.A.F.* .90
- New groups with **5 or fewer** enrolling employees are rated at R.A.F.* 1.10

Final rates are contingent upon actual enrollment and review of applications.

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.

*Risk Adjustment Factor

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

6 to 50 enrolling employees

5 or fewer enrolling employees

\$30/\$1,000 PLAN

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$93	\$254	\$210	\$306	<30	\$113	\$310	\$256	\$374
30–39	\$110	\$293	\$222	\$343	30–39	\$134	\$358	\$270	\$419
40–49	\$148	\$302	\$232	\$384	40–49	\$181	\$369	\$283	\$469
50–54	\$198	\$411	\$271	\$455	50–54	\$242	\$502	\$331	\$556
55–59	\$246	\$511	\$319	\$560	55–59	\$300	\$624	\$389	\$684
60–64	\$315	\$630	\$389	\$697	60–64	\$385	\$770	\$476	\$852
65+	\$382	\$871	\$453	\$914	65+	\$467	\$1,064	\$554	\$1,116

\$20/\$1,000 PLAN

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$105	\$287	\$237	\$346	<30	\$128	\$351	\$290	\$423
30–39	\$124	\$331	\$250	\$387	30–39	\$151	\$404	\$305	\$473
40–49	\$167	\$341	\$261	\$433	40–49	\$204	\$417	\$319	\$530
50–54	\$223	\$463	\$306	\$513	50–54	\$273	\$567	\$374	\$628
55–59	\$277	\$576	\$359	\$631	55–59	\$339	\$705	\$440	\$773
60–64	\$355	\$711	\$439	\$787	60–64	\$434	\$869	\$537	\$962
65+	\$431	\$983	\$512	\$1,031	65+	\$527	\$1,202	\$625	\$1,261

\$10/\$1,000 PLAN

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	\$134	\$366	\$303	\$441
30–39	\$129	\$345	\$261	\$404	30–39	\$158	\$422	\$319	\$494
40–49	\$175	\$357	\$274	\$453	40–49	\$213	\$435	\$333	\$553
50–54	\$233	\$484	\$319	\$536	50–54	\$285	\$592	\$390	\$655
55–59	\$290	\$603	\$376	\$661	55–59	\$354	\$736	\$459	\$807
60–64	\$371	\$743	\$459	\$822	60–64	\$454	\$908	\$561	\$1,005
65+	\$450	\$1,026	\$534	\$1,076	65+	\$550	\$1,254	\$653	\$1,316

Copayment Plans

PLAN HIGHLIGHTS

FEATURES	\$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	\$0	\$250 for brand prescriptions	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM[§]					
Individual/Family	\$3,500/\$7,000	\$3,000/\$6,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000
IN THE MEDICAL OFFICE					
Office visits	\$50	\$30	\$20	\$15	\$5
Preventive physical, vision, and hearing exams	\$50	\$30	\$20	\$15	\$5
Maternity/prenatal care*	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits**	\$15	\$0	\$0	\$0	\$0
Immunizations	\$0	\$0	\$0	\$0	\$0
Allergy injections	\$5	\$5	\$5	\$5	\$0
Infertility services	Not covered	Not covered	Not covered	50%	50%
Occupational, physical, and speech therapy	\$50	\$30	\$20	\$15	\$5
Lab and imaging	\$10	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50	\$50
Outpatient surgery	\$250	\$100	\$50	\$50	\$5
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$100	\$100	\$100	\$100
Ambulance	\$300	\$75	\$75	\$75	\$75
PRESCRIPTIONS***		(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	Not covered	\$10	\$10	\$10	\$5
Brand	Not covered	\$35 (after Pharmacy deductible)	\$30	\$25	\$15
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day	\$200 per day	\$100 per day	\$100 per day	\$0
Skilled Nursing Facility care (up to 100 days per benefit period)	\$0	\$0	\$0	\$0	\$0
MENTAL HEALTH SERVICES****					
In the medical office (up to 20 visits per Calendar Year)	\$50 individual \$25 group therapy	\$30 individual \$15 group therapy	\$20 individual \$10 group therapy	\$15 individual \$7 group therapy	\$5 individual \$2 group therapy
In the hospital (up to 30 days per Calendar Year)	\$500 per day	\$200 per day	\$100 per day	\$100 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	\$200 per day	\$100 per day	\$100 per day	\$0
OTHER					
Durable Medical Equipment (DME) DME used in the home in accord with our DME formulary	Not covered	Not covered	20% (\$2,000 maximum)	20% (\$2,000 maximum)	20% (\$2,000 maximum)
Optical (eyewear)	Not covered	Not covered	Not covered	\$150 allowance*****	\$150 allowance*****
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

[§] 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*).

* Scheduled prenatal visits and the first postpartum visit.

** 23 months or younger.

*** Prescription drugs 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.

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

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

This chart is a summary only. Additional information is provided in the Group's *Evidence of Coverage*.

RATE AREA 5

Copayment Plans

RATES

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

- New groups with **6 to 50** enrolling employees are rated at R.A.F.* .90
- New groups with **5 or fewer** enrolling employees are rated at R.A.F.* 1.10

Final rates are contingent upon actual enrollment and review of applications.

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.

*Risk Adjustment Factor

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

6 to 50 enrolling employees					5 or fewer enrolling employees				
\$50 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$98	\$274	\$266	\$381	<30	\$120	\$335	\$326	\$466
30-39	\$108	\$294	\$277	\$421	30-39	\$133	\$361	\$339	\$516
40-49	\$140	\$322	\$266	\$425	40-49	\$171	\$393	\$325	\$519
50-54	\$182	\$378	\$290	\$473	50-54	\$223	\$463	\$355	\$579
55-59	\$230	\$483	\$331	\$535	55-59	\$281	\$590	\$405	\$654
60-64	\$284	\$539	\$380	\$629	60-64	\$347	\$659	\$464	\$769
65+	\$306	\$674	\$484	\$765	65+	\$374	\$824	\$591	\$935
\$30 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$114	\$319	\$310	\$444	<30	\$140	\$390	\$379	\$543
30-39	\$126	\$343	\$322	\$491	30-39	\$154	\$419	\$394	\$600
40-49	\$163	\$375	\$309	\$495	40-49	\$199	\$458	\$378	\$604
50-54	\$212	\$441	\$338	\$551	50-54	\$259	\$538	\$413	\$673
55-59	\$268	\$562	\$386	\$623	55-59	\$327	\$687	\$471	\$761
60-64	\$330	\$627	\$441	\$732	60-64	\$404	\$767	\$540	\$895
65+	\$356	\$784	\$563	\$889	65+	\$436	\$959	\$689	\$1,088
\$20 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$134	\$375	\$364	\$522	<30	\$164	\$458	\$445	\$637
30-39	\$148	\$402	\$379	\$576	30-39	\$181	\$492	\$463	\$704
40-49	\$191	\$440	\$363	\$581	40-49	\$234	\$538	\$444	\$710
50-54	\$249	\$517	\$397	\$647	50-54	\$304	\$632	\$485	\$791
55-59	\$315	\$661	\$454	\$732	55-59	\$384	\$807	\$553	\$894
60-64	\$388	\$737	\$519	\$860	60-64	\$474	\$900	\$634	\$1,051
65+	\$419	\$922	\$662	\$1,046	65+	\$512	\$1,126	\$809	\$1,277
\$15 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$149	\$417	\$405	\$580	<30	\$182	\$509	\$495	\$709
30-39	\$165	\$448	\$422	\$641	30-39	\$202	\$548	\$516	\$784
40-49	\$213	\$490	\$405	\$647	40-49	\$260	\$598	\$494	\$789
50-54	\$277	\$576	\$441	\$720	50-54	\$339	\$704	\$540	\$880
55-59	\$350	\$735	\$504	\$815	55-59	\$428	\$899	\$617	\$996
60-64	\$432	\$820	\$578	\$957	60-64	\$528	\$1,003	\$706	\$1,171
65+	\$466	\$1,026	\$736	\$1,164	65+	\$570	\$1,254	\$900	\$1,422
\$5 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$182	\$509	\$495	\$708	<30	\$223	\$622	\$605	\$866
30-39	\$201	\$547	\$514	\$783	30-39	\$246	\$668	\$629	\$956
40-49	\$260	\$598	\$494	\$789	40-49	\$317	\$730	\$603	\$963
50-54	\$338	\$703	\$539	\$879	50-54	\$413	\$859	\$658	\$1,074
55-59	\$427	\$897	\$615	\$994	55-59	\$522	\$1,096	\$752	\$1,215
60-64	\$527	\$1,001	\$705	\$1,168	60-64	\$644	\$1,223	\$861	\$1,428
65+	\$569	\$1,252	\$899	\$1,420	65+	\$695	\$1,529	\$1,098	\$1,734

\$25 POS Plan PLAN HIGHLIGHTS

If your employee selects the HMO option 20,
the benefits are as follows:

If your employee selects the Point-of-Service option 25,
the benefits are as follows:

FEATURES	MEMBER PAYS	MEMBER PAYS		
		Kaiser Permanente Plan Providers (HMO) (In-network)	CCN Providers* [†] (PPO)	Non-Participating Providers* [†] (Out-of-network)
MEDICAL CALENDAR YEAR DEDUCTIBLE Individual/Family	\$0	\$0		\$500 ¹ /\$1,000 ¹
MAXIMUM BENEFIT WHILE INSURED				\$2,000,000
PHARMACY CALENDAR YEAR DEDUCTIBLE	\$0	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM [§] (Calendar Year)	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$3,000 individual ² \$9,000 family ²	\$6,000 individual ² \$18,000 family ²
IN THE MEDICAL OFFICE				
Office visits	\$20	\$25	30%	50%
Preventive physical, vision, and hearing exams	\$20	\$25	Not covered	Not covered
Maternity/prenatal care ³	\$0	\$0	30%	50%
Well-child preventive care visits	\$0 ⁴	\$0 ⁴	30%	50%
Immunizations	\$0	\$0	Not covered	Not covered
Allergy injections	\$5	\$5	Not covered	Not covered
Infertility services	Not covered	Not covered ⁵	Not covered ⁵	Not covered ⁵
Occupational, physical, and speech therapy	\$20	\$25	30%	50%
Lab and imaging	\$10	\$10	30%	50%
MRI/CT/PET	\$50	\$50	30%	50%
Outpatient surgery	\$50	\$50	30%	50%
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	\$100	\$100	Emergency Department visits and ambulance for emergency medical conditions are covered as an HMO benefit for Services received at any provider.	
Ambulance	\$75	\$75		
PRESCRIPTIONS	Obtained at Kaiser Permanente Plan Pharmacies (including affiliated pharmacies) ⁶	Obtained at Kaiser Permanente Plan Pharmacies (including affiliated pharmacies) ⁶	Obtained at Participating MedCare Pharmacies ⁷	
Generic	\$10	\$10	\$15	Not covered
Brand	\$30	\$35	\$35	Not covered
Most non-formulary	N/A	\$40	\$40	Not covered
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies	\$100 per day	\$100 per day	30%	50%
Skilled Nursing Facility care	\$0 (100-day limit per benefit period)	\$0 (100-day limit per benefit period)	30%	50%
			(combined 60-day limit per Calendar Year)	
MENTAL HEALTH SERVICES**				
In the medical office (up to 20 visits per Calendar Year)	\$20 individual \$10 group therapy	\$25 individual \$12 group therapy	Not covered Not covered	Not covered Not covered
In the hospital (up to 30 days per Calendar Year)	\$100 per day	\$100 per day	Not covered	Not covered
CHEMICAL DEPENDENCY SERVICES				
In the medical office (counseling for dependency; medical management of withdrawal symptoms)	\$20 individual \$5 group therapy	\$25 individual \$5 group therapy	Not covered Not covered	Not covered Not covered
In the hospital (medical management of withdrawal symptoms)	\$100 per day	\$100 per day	Not covered	Not covered
OTHER				
Durable Medical Equipment (DME) DME used during a covered stay in a Plan Hospital or a Skilled Nursing Facility	\$0	\$0	30%	50%
DME used in the home	20% (\$2,000 maximum)	20% (\$2,000 maximum)	(combined \$2,000 maximum per Calendar Year) 30%	(combined \$2,000 maximum per Calendar Year) 50%
Optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Vision exam	\$20	\$25	Not covered	Not covered
Home health care	\$0 (100 two-hour visits per Calendar Year)	\$0 (100 two-hour visits per Calendar Year)	20% ⁸	20% ⁸
Hospice care	\$0	\$0	30%	50%
			(combined 180-day limit per Calendar Year)	

[§] 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* and the *Certificate of Insurance*).

*Based on Maximum Allowable Charge.

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

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 POS Plan Evidence of Coverage and the Kaiser Permanente Insurance Company Certificate of Insurance. See important information on page 10.

RATES

\$25 POS Plan

RATE AREA 5

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

- New groups with **6 to 50** enrolling employees are rated at R.A.F.* .90
- New groups with **5 or fewer** enrolling employees are rated at R.A.F.* 1.10

Final rates are contingent upon actual enrollment and review of applications.

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.

*Risk Adjustment Factor

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

6 to 50 enrolling employees**5 or fewer enrolling employees****HMO OPTION 20**

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$134	\$375	\$364	\$522	<30	\$164	\$458	\$445	\$637
30–39	\$148	\$402	\$379	\$576	30–39	\$181	\$492	\$463	\$704
40–49	\$191	\$440	\$363	\$581	40–49	\$234	\$538	\$444	\$710
50–54	\$249	\$517	\$397	\$647	50–54	\$304	\$632	\$485	\$791
55–59	\$315	\$661	\$454	\$732	55–59	\$384	\$807	\$553	\$894
60–64	\$388	\$737	\$519	\$860	60–64	\$474	\$900	\$634	\$1,051
65+	\$419	\$922	\$662	\$1,046	65+	\$512	\$1,126	\$809	\$1,277

POINT-OF-SERVICE OPTION 25

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$187	\$505	\$470	\$708	<30	\$228	\$616	\$574	\$865
30–39	\$207	\$562	\$528	\$804	30–39	\$252	\$685	\$645	\$981
40–49	\$266	\$613	\$506	\$809	40–49	\$326	\$750	\$619	\$990
50–54	\$347	\$721	\$585	\$915	50–54	\$424	\$881	\$715	\$1,118
55–59	\$438	\$921	\$670	\$1,067	55–59	\$535	\$1,125	\$819	\$1,303
60–64	\$507	\$1,015	\$723	\$1,198	60–64	\$620	\$1,241	\$884	\$1,465
65+	\$605	\$1,282	\$922	\$1,456	65+	\$740	\$1,567	\$1,127	\$1,780

\$35 POS Plan **PLAN HIGHLIGHTS**

If your employee selects the HMO option 30,
the benefits are as follows:

If your employee selects the Point-of-Service option 35,
the benefits are as follows:

FEATURES	MEMBER PAYS	Kaiser Permanente Plan Providers* ¹ (In-network)	CCN Providers* ¹ (PPO)	Non-Participating Providers* ¹ (Out-of-network)
		MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR YEAR DEDUCTIBLE Individual/Family	\$0	\$0		\$500 ¹ /\$1,000 ¹
MAXIMUM BENEFIT WHILE INSURED				\$2,000,000
PHARMACY CALENDAR YEAR DEDUCTIBLE	\$250	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM [§] (Calendar Year)	\$3,000 individual \$6,000 family	\$3,000 individual \$6,000 family	\$3,000 individual ² \$9,000 family ²	\$6,000 individual ² \$18,000 family ²
IN THE MEDICAL OFFICE				
Office visits	\$30	\$35	30%	50%
Preventive physical, vision, and hearing exams	\$30	\$35	Not covered	Not covered
Maternity/prenatal care ³	\$0	\$0	30%	50%
Well-child preventive care visits	\$0 ⁴	\$0 ⁴	30%	50%
Immunizations	\$0	\$0	Not covered	Not covered
Allergy injections	\$5	\$5	Not covered	Not covered
Infertility services	Not covered	Not covered ⁵	Not covered ⁵	Not covered ⁵
Occupational, physical, and speech therapy	\$30	\$35	30%	50%
Lab and imaging	\$10	\$10	30%	50%
MRI/CT/PET	\$50	\$50	30%	50%
Outpatient surgery	\$100	\$100	30%	50%
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	\$100	\$100	Emergency Department visits and ambulance for emergency medical conditions are covered as an HMO benefit for Services received at any provider.	
Ambulance	\$75	\$75		
PRESCRIPTIONS	Obtained at Kaiser Permanente Plan Pharmacies (including affiliated pharmacies) ⁶	Obtained at Kaiser Permanente Plan Pharmacies (including affiliated pharmacies) ⁶	Obtained at Participating MedCare Pharmacies ⁷	
Generic	\$10	\$10	\$15	Not covered
Brand	\$35 (after \$250 deductible)	\$35	\$35	Not covered
Most non-formulary	N/A	\$40	\$40	Not covered
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies	\$200 per day	\$200 per day	30%	50%
Skilled Nursing Facility care	\$0 (100-day limit per benefit period)	\$0 (100-day limit per benefit period)	30% (combined 60-day limit per Calendar Year)	50% (combined 60-day limit per Calendar Year)
MENTAL HEALTH SERVICES**				
In the medical office (up to 20 visits per Calendar Year)	\$30 individual \$15 group therapy	\$35 individual \$17 group therapy	Not covered Not covered	Not covered Not covered
In the hospital (up to 30 days per Calendar Year)	\$200 per day	\$200 per day	Not covered	Not covered
CHEMICAL DEPENDENCY SERVICES				
In the medical office (counseling for dependency; medical management of withdrawal symptoms)	\$30 individual \$5 group therapy	\$35 individual \$5 group therapy	Not covered Not covered	Not covered Not covered
In the hospital (medical management of withdrawal symptoms)	\$200 per day	\$200 per day	Not covered	Not covered
OTHER				
Durable Medical Equipment (DME) DME used during a covered stay in a Plan Hospital or a Skilled Nursing Facility	\$0	\$0	30% (combined \$2,000 maximum per Calendar Year)	50% (combined \$2,000 maximum per Calendar Year)
DME used in the home	Not covered	Not covered	30% (combined \$2,000 maximum per Calendar Year)	50% (combined \$2,000 maximum per Calendar Year)
Optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Vision exam	\$30	\$35	Not covered	Not covered
Home health care (100 two-hour visits per Calendar Year)	\$0	\$0	20% ⁸	20% ⁸
Hospice care	\$0	\$0	30% (combined 180-day limit per Calendar Year)	50% (combined 180-day limit per Calendar Year)

[§] 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* and the *Certificate of Insurance*).

* Based on Maximum Allowable Charge.

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

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 POS Plan Evidence of Coverage and the Kaiser Permanente Insurance Company Certificate of Insurance. See important information on page 10.

RATE AREA 5

RATES

\$35 POS Plan

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

- New groups with **6 to 50** enrolling employees are rated at R.A.F.* .90
- New groups with **5 or fewer** enrolling employees are rated at R.A.F.* 1.10

Final rates are contingent upon actual enrollment and review of applications.

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.

*Risk Adjustment Factor

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

6 to 50 enrolling employees

5 or fewer enrolling employees

HMO OPTION 30

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$114	\$319	\$310	\$444	<30	\$140	\$390	\$379	\$543
30–39	\$126	\$343	\$322	\$491	30–39	\$154	\$419	\$394	\$600
40–49	\$163	\$375	\$309	\$495	40–49	\$199	\$458	\$378	\$604
50–54	\$212	\$441	\$338	\$551	50–54	\$259	\$538	\$413	\$673
55–59	\$268	\$562	\$386	\$623	55–59	\$327	\$687	\$471	\$761
60–64	\$330	\$627	\$441	\$732	60–64	\$404	\$767	\$540	\$895
65+	\$356	\$784	\$563	\$889	65+	\$436	\$959	\$689	\$1,088

POINT-OF-SERVICE OPTION 35

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$182	\$491	\$458	\$689	<30	\$223	\$601	\$560	\$843
30–39	\$201	\$546	\$514	\$782	30–39	\$246	\$668	\$629	\$956
40–49	\$260	\$598	\$494	\$789	40–49	\$317	\$730	\$602	\$963
50–54	\$338	\$702	\$570	\$891	50–54	\$413	\$858	\$696	\$1,089
55–59	\$426	\$896	\$652	\$1,038	55–59	\$521	\$1,096	\$797	\$1,269
60–64	\$494	\$989	\$704	\$1,167	60–64	\$604	\$1,209	\$861	\$1,427
65+	\$589	\$1,248	\$897	\$1,418	65+	\$720	\$1,526	\$1,097	\$1,734

FOOTNOTES

- 1 Deductible amounts are combined for Services provided by CCN Providers and Non-Participating Providers. Deductibles do not count toward satisfying the Out-of-Pocket Maximum.
- 2 Covered charges incurred to satisfy the Out-of-Pocket Maximum at the CCN Providers level will not be applicable toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Providers level. However, Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Providers level will continue to be applicable toward satisfaction of the Out-of-Pocket Maximum at the CCN Providers level.
- 3 Scheduled prenatal visits and first postpartum visit.
- 4 Covered by Kaiser Permanente Plan Providers (HMO) only to age 23 months or younger.
- 5 In accordance with California law, health plans and insurers are required to offer contractholders 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 dues, please contact your broker or the Renewal Management Team at **1-800-790-4661**.
- 6 A few drugs have different copayments. Please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.
- 7 Participating MedCare Pharmacy copayments and deductibles are not subject to, nor do they contribute toward satisfaction of, the Calendar Year Deductible or the Out-of-Pocket Maximum. Select prescription medications are excluded from coverage. Participating MedCare Pharmacies are Albertsons, Kmart, Longs, Raley's, Rite Aid, Safeway, Sav-on, Vons, and Walgreens.
- 8 Home health care is limited to a maximum of 100 visits per Calendar Year combined for Services provided by CCN Providers and Non-Participating Providers. Deductible amount is limited to a maximum of \$50 per Calendar Year.

†Precertification of services provided by CCN Providers and Non-Participating 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 Non-Participating 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 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 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 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.

HMO Exclusions and Limitations

Please refer to the *Disclosure Form*. Previous pages refer to the *Evidence of Coverage*.

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 the Renewal Management Team at **1-800-790-4661**.

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 Non-Participating 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 Providers. Together they are dedicated to delivering competitively priced quality health care for small businesses.

Rate Area 5

Below is a listing of all ZIP codes within Rate Area 5.

Orange County is entirely within Rate Area 5.

Portions of the following counties are also within Rate Area 5:
Imperial, Los Angeles, and San Diego.

90001-84	90680	91131	91921	92186-87
90086-89	90701-03	91175	91931-33	92190-99
90091	90706-07	91182	91935	92275
90093-97	90710-17	91184-89	91941-47	92602-07
90099	90720-21	91191	91950-51	92609-10
90101-03	90723	91201-10	91962-63	92612
90174	90731-34	91214	91976-80	92614-20
90185	90740	91221-22	91987	92623-30
90189	90742-49	91224-26	91990	92637
90201-02	90755	91501-08	92007-09	92646-63
90209-13	90801-10	91510	92013-14	92672-79
90220-24	90813-15	91521-23	92018-27	92683-85
90230-33	90822	91526	92029-30	92688
90239-42	90831-35	91702	92033	92690-94
90245	90840	91706	92037-40	92697-98
90247-51	90842	91711	92046	92701-12
90254-55	90844-48	91714-16	92049	92725
90260-67	90853	91722-24	92051-52	92728
90270	90888	91731-35	92054-58	92735
90272	90899	91740-41	92064-65	92780-82
90274-75	91001	91744-50	92067-69	92799
90277-78	91003	91754-56	92071-72	92801-09
90280	91006-07	91759	92074-75	92811-12
90290-96	91009-12	91765-73	92078-79	92814-17
90301-13	91016-17	91775-76	92081-85	92821-23
90397-98	91020-21	91778	92090-93	92825
90401-11	91023-25	91780	92096	92831-38
90501-10	91030-31	91788-93	92101-24	92840-46
90601-10	91040-43	91795	92126-40	92850
90612	91046	91797	92142-43	92856-57
90620-24	91066	91799	92145	92859
90630-33	91077	91801-04	92147	92861-71
90637-40	91101-10	91841	92149-50	92885-87
90650-52	91114-18	91896	92152-55	92899
90659-62	91121	91899	92158-79	
90665	91123-26	91901-03	92182	
90670-71	91129	91908-17	92184	



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