

FOR OUR SMALL BUSINESS GROUPS

Effective April–June 2005

Rate Area 8

Plan Highlights and Rates

2005 SMALL BUSINESS

For New Groups

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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 8

RATES

Deductible Plans

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	\$121	\$331	\$273	\$399	<30	\$147	\$403	\$333	\$486
30-39	\$142	\$380	\$287	\$445	30-39	\$174	\$465	\$351	\$544
40-49	\$193	\$393	\$302	\$499	40-49	\$235	\$480	\$368	\$610
50-54	\$257	\$534	\$352	\$591	50-54	\$314	\$652	\$430	\$722
55-59	\$319	\$664	\$414	\$728	55-59	\$390	\$811	\$506	\$889
60-64	\$409	\$819	\$506	\$906	60-64	\$500	\$1,001	\$618	\$1,108
65+	\$496	\$1,131	\$589	\$1,186	65+	\$607	\$1,384	\$720	\$1,452

\$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	\$136	\$373	\$308	\$449	<30	\$167	\$457	\$378	\$550
30-39	\$161	\$430	\$325	\$503	30-39	\$197	\$526	\$397	\$616
40-49	\$218	\$445	\$341	\$565	40-49	\$266	\$543	\$416	\$690
50-54	\$291	\$604	\$398	\$669	50-54	\$355	\$737	\$486	\$816
55-59	\$361	\$751	\$468	\$823	55-59	\$441	\$917	\$572	\$1,005
60-64	\$463	\$926	\$572	\$1,025	60-64	\$565	\$1,131	\$699	\$1,252
65+	\$561	\$1,279	\$666	\$1,342	65+	\$686	\$1,564	\$814	\$1,641

\$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	\$142	\$389	\$322	\$469	<30	\$174	\$476	\$394	\$574
30-39	\$168	\$449	\$339	\$526	30-39	\$205	\$549	\$414	\$643
40-49	\$227	\$464	\$355	\$590	40-49	\$278	\$567	\$435	\$720
50-54	\$304	\$631	\$416	\$698	50-54	\$371	\$770	\$508	\$852
55-59	\$377	\$784	\$489	\$859	55-59	\$461	\$958	\$598	\$1,050
60-64	\$483	\$967	\$597	\$1,070	60-64	\$590	\$1,181	\$729	\$1,307
65+	\$586	\$1,336	\$695	\$1,402	65+	\$716	\$1,633	\$850	\$1,713

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*.

RATES

Copayment Plans

RATE AREA 8

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	\$128	\$357	\$347	\$497	<30	\$156	\$436	\$424	\$607
30-39	\$141	\$383	\$360	\$548	30-39	\$172	\$468	\$440	\$670
40-49	\$182	\$419	\$346	\$553	40-49	\$222	\$511	\$422	\$675
50-54	\$237	\$492	\$378	\$615	50-54	\$289	\$601	\$461	\$752
55-59	\$299	\$628	\$431	\$696	55-59	\$366	\$768	\$527	\$851
60-64	\$369	\$701	\$494	\$818	60-64	\$451	\$857	\$603	\$1,000
65+	\$398	\$876	\$629	\$994	65+	\$487	\$1,071	\$769	\$1,215
\$30 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$149	\$416	\$404	\$579	<30	\$182	\$508	\$494	\$707
30-39	\$164	\$446	\$420	\$639	30-39	\$201	\$546	\$514	\$782
40-49	\$212	\$488	\$403	\$644	40-49	\$259	\$596	\$492	\$787
50-54	\$276	\$574	\$440	\$718	50-54	\$337	\$701	\$537	\$877
55-59	\$349	\$733	\$503	\$812	55-59	\$426	\$895	\$614	\$992
60-64	\$430	\$817	\$575	\$954	60-64	\$526	\$999	\$703	\$1,166
65+	\$464	\$1,022	\$733	\$1,159	65+	\$568	\$1,250	\$897	\$1,418
\$20 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$175	\$489	\$475	\$680	<30	\$214	\$598	\$581	\$832
30-39	\$193	\$525	\$494	\$752	30-39	\$236	\$642	\$604	\$919
40-49	\$249	\$573	\$473	\$756	40-49	\$305	\$702	\$579	\$926
50-54	\$325	\$675	\$518	\$844	50-54	\$397	\$825	\$633	\$1,032
55-59	\$410	\$861	\$591	\$954	55-59	\$501	\$1,053	\$722	\$1,167
60-64	\$506	\$961	\$677	\$1,122	60-64	\$618	\$1,174	\$827	\$1,371
65+	\$546	\$1,202	\$863	\$1,363	65+	\$667	\$1,468	\$1,054	\$1,665
\$15 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$195	\$544	\$529	\$757	<30	\$238	\$665	\$647	\$925
30-39	\$215	\$585	\$550	\$837	30-39	\$263	\$715	\$672	\$1,023
40-49	\$278	\$639	\$528	\$843	40-49	\$339	\$780	\$644	\$1,030
50-54	\$361	\$751	\$576	\$939	50-54	\$442	\$918	\$704	\$1,148
55-59	\$457	\$959	\$658	\$1,063	55-59	\$558	\$1,172	\$804	\$1,299
60-64	\$563	\$1,070	\$753	\$1,249	60-64	\$688	\$1,307	\$920	\$1,526
65+	\$608	\$1,338	\$960	\$1,518	65+	\$743	\$1,635	\$1,174	\$1,855
\$5 PLAN									
Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$238	\$664	\$646	\$924	<30	\$290	\$811	\$788	\$1,129
30-39	\$263	\$714	\$672	\$1,022	30-39	\$321	\$872	\$820	\$1,248
40-49	\$339	\$780	\$644	\$1,029	40-49	\$414	\$953	\$787	\$1,258
50-54	\$441	\$917	\$703	\$1,147	50-54	\$539	\$1,120	\$859	\$1,401
55-59	\$557	\$1,170	\$803	\$1,297	55-59	\$681	\$1,430	\$981	\$1,585
60-64	\$687	\$1,305	\$919	\$1,523	60-64	\$840	\$1,596	\$1,123	\$1,863
65+	\$742	\$1,633	\$1,172	\$1,852	65+	\$907	\$1,996	\$1,433	\$2,264

Paired Option PLAN HIGHLIGHTS

If your employee selects the \$30/\$1,000 Deductible Plan, the benefits are as follows:

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

If your employee selects the \$20 Copayment Plan, the benefits are as follows:

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

RATES

Paired Option

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

PAIRED OPTION – \$30/\$1,000 DEDUCTIBLE PLAN

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$125	\$342	\$283	\$412	<30	\$153	\$418	\$346	\$504
30–39	\$147	\$394	\$297	\$461	30–39	\$180	\$481	\$364	\$563
40–49	\$199	\$406	\$311	\$516	40–49	\$244	\$498	\$381	\$633
50–54	\$266	\$553	\$364	\$612	50–54	\$325	\$675	\$445	\$747
55–59	\$331	\$688	\$429	\$754	55–59	\$404	\$840	\$524	\$921
60–64	\$424	\$848	\$524	\$938	60–64	\$518	\$1,036	\$640	\$1,146
65+	\$514	\$1,172	\$610	\$1,229	65+	\$628	\$1,432	\$745	\$1,502

PAIRED OPTION – \$20 COPAYMENT PLAN

Age	EE Only	EE+S	EE+C	EE+S+C	Age	EE Only	EE+S	EE+C	EE+S+C
<30	\$181	\$506	\$492	\$704	<30	\$221	\$618	\$601	\$860
30–39	\$200	\$544	\$511	\$779	30–39	\$245	\$665	\$626	\$952
40–49	\$258	\$594	\$490	\$784	40–49	\$316	\$726	\$600	\$958
50–54	\$336	\$698	\$536	\$873	50–54	\$411	\$854	\$655	\$1,068
55–59	\$425	\$892	\$612	\$988	55–59	\$519	\$1,090	\$748	\$1,208
60–64	\$524	\$995	\$701	\$1,161	60–64	\$640	\$1,216	\$856	\$1,419
65+	\$565	\$1,244	\$893	\$1,411	65+	\$691	\$1,521	\$1,092	\$1,725

\$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	Kaiser Permanente Plan Providers (HMO) (In-network)	CCN Providers* [†] (PPO)	Non-Participating Providers* [†] (Out-of-network)
		MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR YEAR DEDUCTIBLE Individual/Family	\$0	\$0	\$500 ¹ /\$1,000 ¹	
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% (combined 60-day limit per Calendar Year)	
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	Not covered
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% (combined 60-day limit per Calendar Year)	50%
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% (combined \$2,000 maximum per Calendar Year)	50%
DME used in the home	20% (\$2,000 maximum)	20% (\$2,000 maximum)	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% (combined 180-day limit per Calendar Year)	50%

[§] 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 12.

RATES

\$25 POS Plan

RATE AREA 8

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	\$175	\$489	\$475	\$680	<30	\$214	\$598	\$581	\$832
30-39	\$193	\$525	\$494	\$752	30-39	\$236	\$642	\$604	\$919
40-49	\$249	\$573	\$473	\$756	40-49	\$305	\$702	\$579	\$926
50-54	\$325	\$675	\$518	\$844	50-54	\$397	\$825	\$633	\$1,032
55-59	\$410	\$861	\$591	\$954	55-59	\$501	\$1,053	\$722	\$1,167
60-64	\$506	\$961	\$677	\$1,122	60-64	\$618	\$1,174	\$827	\$1,371
65+	\$546	\$1,202	\$863	\$1,363	65+	\$667	\$1,468	\$1,054	\$1,665

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	\$244	\$658	\$614	\$923	<30	\$298	\$805	\$750	\$1,129
30-39	\$269	\$732	\$688	\$1,048	30-39	\$329	\$894	\$841	\$1,280
40-49	\$348	\$800	\$661	\$1,056	40-49	\$425	\$978	\$807	\$1,291
50-54	\$452	\$940	\$762	\$1,193	50-54	\$553	\$1,149	\$932	\$1,458
55-59	\$571	\$1,201	\$874	\$1,391	55-59	\$698	\$1,468	\$1,068	\$1,700
60-64	\$662	\$1,325	\$943	\$1,564	60-64	\$809	\$1,619	\$1,153	\$1,911
65+	\$789	\$1,672	\$1,202	\$1,900	65+	\$965	\$2,044	\$1,470	\$2,322

\$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 (HMO) (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	
PHARMACY CALENDAR YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$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% (combined 60-day limit per Calendar Year)	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%
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%
DME used in the home	Not covered	Not covered	30% (combined \$2,000 maximum per Calendar Year)	50%
Optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Vision exam	\$30	\$35	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% (combined 180-day limit per Calendar Year)	50%

[§] 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 12.

RATES

\$35 POS Plan

RATE AREA 8

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	\$149	\$416	\$404	\$579	< 30	\$182	\$508	\$494	\$707
30–39	\$164	\$446	\$420	\$639	30–39	\$201	\$546	\$514	\$782
40–49	\$212	\$488	\$403	\$644	40–49	\$259	\$596	\$492	\$787
50–54	\$276	\$574	\$440	\$718	50–54	\$337	\$701	\$537	\$877
55–59	\$349	\$733	\$503	\$812	55–59	\$426	\$895	\$614	\$992
60–64	\$430	\$817	\$575	\$954	60–64	\$526	\$999	\$703	\$1,166
65+	\$464	\$1,022	\$733	\$1,159	65+	\$568	\$1,250	\$897	\$1,418

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	\$238	\$642	\$598	\$901	< 30	\$290	\$783	\$730	\$1,099
30–39	\$262	\$713	\$670	\$1,021	30–39	\$321	\$872	\$820	\$1,248
40–49	\$339	\$779	\$644	\$1,028	40–49	\$414	\$952	\$786	\$1,256
50–54	\$441	\$916	\$743	\$1,162	50–54	\$539	\$1,120	\$909	\$1,421
55–59	\$556	\$1,169	\$851	\$1,354	55–59	\$680	\$1,430	\$1,040	\$1,656
60–64	\$645	\$1,291	\$919	\$1,524	60–64	\$788	\$1,577	\$1,123	\$1,861
65+	\$769	\$1,629	\$1,171	\$1,851	65+	\$940	\$1,991	\$1,432	\$2,262

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. Lifetime maximum is \$2,000,000 combined for Services provided by CCN Providers and Non-Participating Providers.
- 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*. Plan Highlights 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 8

Below is a listing of all ZIP codes within Rate Area 8.

Portions of the following counties
are within Rate Area 8:
Riverside and San Bernardino.

92201-03	92234-36	92260-64	92282
92210-11	92240-41	92268	92284-86
92220	92247-48	92270	92292
92223	92252-56	92274	
92230	92258	92276-78	



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