

FOR OUR SMALL BUSINESS GROUPS

Effective July–December 2006

Rate Area 1

Plan highlights and rates

2006 SMALL BUSINESS

For new groups

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FOR OUR SMALL BUSINESS GROUPS

On these pages you'll find an overview of benefits for all our available plans for small businesses. Team up with Kaiser Permanente for the one-source answer to all your health coverage needs.

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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 MAXIMUM¹					
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 ²	\$15	\$0	\$0	\$0	\$0
Well-child preventive care visits ³	\$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
PRESCRIPTIONS⁴		(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 ⁵	\$10 ⁵	\$10 ⁵	\$5 ⁵
Brand	Not covered	\$35 (after pharmacy deductible)	\$30 ⁵	\$25 ⁵	\$15 ⁵
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 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	\$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					
Certain durable medical equipment (DME) ⁷ 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 ⁸	\$150 allowance ⁸
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

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.

⁸Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

Copayment plans

RATE AREA 1

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

16 to 50 enrolling employees RAF* .90					6 to 15 enrolling employees RAF* 1.00					5 or fewer enrolling employees RAF* 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	\$123	\$344	\$338	\$479	<30	\$137	\$383	\$376	\$533	<30	\$151	\$421	\$414	\$586
30–39	\$136	\$370	\$348	\$530	30–39	\$151	\$411	\$387	\$588	30–39	\$167	\$453	\$426	\$648
40–49	\$176	\$405	\$334	\$534	40–49	\$195	\$449	\$371	\$593	40–49	\$215	\$495	\$408	\$653
50–54	\$229	\$476	\$378	\$608	50–54	\$254	\$528	\$419	\$675	50–54	\$280	\$582	\$462	\$744
55–59	\$289	\$607	\$432	\$698	55–59	\$321	\$674	\$480	\$775	55–59	\$354	\$743	\$529	\$854
60–64	\$357	\$678	\$477	\$791	60–64	\$396	\$753	\$530	\$879	60–64	\$436	\$828	\$583	\$967
65+	\$405	\$875	\$609	\$962	65+	\$449	\$971	\$675	\$1,067	65+	\$494	\$1,068	\$743	\$1,174
\$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	\$147	\$410	\$403	\$570	<30	\$163	\$455	\$447	\$633	<30	\$179	\$500	\$492	\$696
30–39	\$162	\$440	\$414	\$630	30–39	\$180	\$489	\$460	\$700	30–39	\$198	\$538	\$506	\$770
40–49	\$209	\$481	\$397	\$635	40–49	\$232	\$534	\$441	\$705	40–49	\$255	\$587	\$485	\$775
50–54	\$272	\$565	\$449	\$722	50–54	\$302	\$628	\$498	\$803	50–54	\$332	\$690	\$548	\$882
55–59	\$344	\$722	\$514	\$830	55–59	\$382	\$802	\$571	\$922	55–59	\$420	\$882	\$628	\$1,014
60–64	\$424	\$805	\$567	\$940	60–64	\$471	\$895	\$630	\$1,045	60–64	\$518	\$984	\$693	\$1,149
65+	\$481	\$1,039	\$723	\$1,142	65+	\$534	\$1,154	\$803	\$1,269	65+	\$587	\$1,269	\$883	\$1,395
\$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	\$171	\$478	\$470	\$665	<30	\$190	\$531	\$522	\$739	<30	\$209	\$584	\$574	\$813
30–39	\$189	\$513	\$483	\$734	30–39	\$210	\$570	\$537	\$816	30–39	\$231	\$627	\$590	\$898
40–49	\$244	\$561	\$463	\$740	40–49	\$271	\$623	\$515	\$822	40–49	\$298	\$685	\$566	\$904
50–54	\$317	\$659	\$523	\$842	50–54	\$352	\$732	\$581	\$936	50–54	\$388	\$806	\$640	\$1,030
55–59	\$401	\$842	\$599	\$968	55–59	\$445	\$935	\$665	\$1,075	55–59	\$490	\$1,029	\$732	\$1,183
60–64	\$494	\$939	\$661	\$1,096	60–64	\$549	\$1,043	\$734	\$1,218	60–64	\$604	\$1,148	\$808	\$1,340
65+	\$561	\$1,212	\$843	\$1,332	65+	\$623	\$1,346	\$937	\$1,480	65+	\$685	\$1,481	\$1,030	\$1,628
\$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	\$186	\$519	\$510	\$722	<30	\$206	\$576	\$566	\$802	<30	\$227	\$634	\$623	\$882
30–39	\$205	\$557	\$524	\$797	30–39	\$228	\$619	\$582	\$886	30–39	\$251	\$681	\$641	\$975
40–49	\$264	\$608	\$502	\$803	40–49	\$294	\$676	\$558	\$892	40–49	\$323	\$743	\$614	\$981
50–54	\$344	\$715	\$567	\$914	50–54	\$382	\$795	\$630	\$1,016	50–54	\$421	\$875	\$694	\$1,118
55–59	\$435	\$913	\$650	\$1,050	55–59	\$483	\$1,015	\$722	\$1,167	55–59	\$532	\$1,117	\$795	\$1,285
60–64	\$537	\$1,020	\$718	\$1,191	60–64	\$596	\$1,132	\$797	\$1,322	60–64	\$656	\$1,246	\$877	\$1,454
65+	\$608	\$1,314	\$914	\$1,445	65+	\$676	\$1,461	\$1,016	\$1,606	65+	\$744	\$1,607	\$1,118	\$1,767
\$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	\$230	\$642	\$632	\$893	<30	\$255	\$713	\$701	\$992	<30	\$281	\$785	\$772	\$1,092
30–39	\$254	\$690	\$649	\$988	30–39	\$282	\$767	\$721	\$1,098	30–39	\$310	\$843	\$793	\$1,207
40–49	\$328	\$754	\$623	\$995	40–49	\$364	\$838	\$692	\$1,106	40–49	\$400	\$921	\$760	\$1,216
50–54	\$426	\$886	\$703	\$1,133	50–54	\$474	\$985	\$782	\$1,259	50–54	\$521	\$1,083	\$859	\$1,384
55–59	\$539	\$1,132	\$806	\$1,302	55–59	\$599	\$1,258	\$895	\$1,447	55–59	\$659	\$1,384	\$985	\$1,592
60–64	\$665	\$1,263	\$889	\$1,474	60–64	\$739	\$1,403	\$988	\$1,638	60–64	\$812	\$1,543	\$1,086	\$1,801
65+	\$754	\$1,629	\$1,133	\$1,791	65+	\$838	\$1,810	\$1,260	\$1,990	65+	\$921	\$1,991	\$1,385	\$2,189

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

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.

*Risk adjustment factor

Deductible plans **PLAN HIGHLIGHTS**

FEATURES	\$30/\$1,000 PLAN MEMBER PAYS	\$30/\$1,500 PLAN MEMBER PAYS	\$30/\$1,500 PLAN with HRA MEMBER PAYS	\$30/\$2,500 PLAN with HRA MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$1,000/\$2,000	\$1,500/\$3,000	\$1,500/\$3,000	\$2,500/\$5,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$250 for brand prescriptions	\$250 for brand prescriptions	\$250 for brand prescriptions
ANNUAL OUT-OF-POCKET MAXIMUM¹ Individual/Family	\$3,500/\$7,000	\$3,500/\$7,000	\$3,000/\$6,000	\$5,000/\$10,000
IN THE MEDICAL OFFICE				
Office visits	\$30 (after deductible)	\$30 (after deductible)	\$30 (after deductible)	\$30 (after deductible)
Preventive physical, vision, and hearing exams	\$30 ²	\$30 ²	\$30 ²	\$30 ²
Maternity/prenatal care ³	\$0 ²	\$0 ²	\$10 ²	\$10 ²
Well-child preventive care visits ⁴	\$0 ²	\$0 ²	\$10 ²	\$10 ²
Immunizations	\$0 ²	\$0 ²	\$0 ²	\$0 ²
Allergy injections	\$5 (after deductible)	\$5 (after deductible)	\$0 ²	\$0 ²
Infertility services	Not covered	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	\$30 (after deductible)	\$30 (after deductible)	\$30 (after deductible)	\$30 (after deductible)
Lab and imaging	\$10 (after deductible)	\$10 (after deductible)	\$10 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$50 (after deductible)	\$50 (after deductible)	\$50 (after deductible)	\$50 (after deductible)
Outpatient surgery	\$100 (after deductible)	\$100 (after deductible)	20% (after deductible)	20% (after deductible)
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	\$100 (after deductible)	\$100 (after deductible)	20% (after deductible)	20% (after deductible)
Ambulance	\$75 (after deductible)	\$75 (after deductible)	\$150 (after deductible)	\$150 (after deductible)
PRESCRIPTIONS⁵	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 100-day supply)	(up to a 100-day supply)
Generic	\$10 ²	\$10 ²	\$10 ²	\$10 ²
Brand	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies	\$500 per day (after deductible)	\$500 per day (after deductible)	20% per admission (after deductible)	20% per admission (after deductible)
Skilled nursing facility care	\$50 per day (after deductible) (up to 60 days per benefit period)	\$50 per day (after deductible) (up to 60 days per benefit period)	20% per day (after deductible) (up to 100 days per benefit period)	20% per day (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES⁶				
In the medical office (up to 20 visits per calendar year)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)	\$30 (after deductible for individual therapy) \$15 (after deductible for group therapy)
In the hospital (up to 30 days per calendar year)	\$500 per day (after deductible)	\$500 per day (after deductible)	20% per admission (after deductible)	20% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES				
In the medical office	\$30 (after deductible for individual therapy)	\$30 (after deductible for individual therapy)	\$30 (after deductible for individual therapy)	\$30 (after deductible for individual therapy)
In the hospital (detoxification only)	\$500 per day (after deductible)	\$500 per day (after deductible)	20% per admission (after deductible)	20% per admission (after deductible)
OTHER				
Certain durable medical equipment (DME) ⁷ DME used in the home in accord with our DME formulary	Not covered	Not covered	Not covered	Not covered
Optical (eyewear)	Not covered	Not covered	Not covered	Not covered
Vision exam	\$30 ²	\$30 ²	\$30 ²	\$30 ²
Home health care (up to 100 two-hour visits per calendar year)	\$0 ²	\$0 ²	\$0 ²	\$0 ²
Hospice care	\$0 ²	\$0 ²	\$0 ²	\$0 ²

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.

RATE AREA 1

Deductible plans

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

16 to 50 enrolling employees RAF* .90					6 to 15 enrolling employees RAF* 1.00					5 or fewer enrolling employees RAF* 1.10				
\$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	\$101	\$277	\$229	\$334	<30	\$112	\$307	\$254	\$370	<30	\$123	\$338	\$279	\$407
30–39	\$119	\$319	\$241	\$373	30–39	\$133	\$355	\$268	\$415	30–39	\$146	\$390	\$295	\$457
40–49	\$161	\$329	\$252	\$418	40–49	\$179	\$366	\$280	\$465	40–49	\$197	\$402	\$308	\$511
50–54	\$215	\$447	\$295	\$495	50–54	\$239	\$497	\$327	\$550	50–54	\$263	\$546	\$360	\$605
55–59	\$268	\$557	\$347	\$610	55–59	\$297	\$618	\$385	\$677	55–59	\$327	\$680	\$424	\$745
60–64	\$343	\$686	\$424	\$759	60–64	\$381	\$762	\$471	\$843	60–64	\$419	\$839	\$518	\$928
65+	\$416	\$948	\$494	\$994	65+	\$462	\$1,053	\$548	\$1,105	65+	\$508	\$1,159	\$603	\$1,216
\$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	\$82	\$225	\$186	\$271	<30	\$91	\$249	\$206	\$300	<30	\$100	\$274	\$227	\$330
30–39	\$97	\$259	\$196	\$303	30–39	\$108	\$288	\$218	\$337	30–39	\$118	\$316	\$239	\$370
40–49	\$131	\$267	\$205	\$339	40–49	\$146	\$298	\$228	\$378	40–49	\$160	\$327	\$250	\$415
50–54	\$175	\$363	\$240	\$402	50–54	\$194	\$403	\$266	\$446	50–54	\$214	\$444	\$293	\$492
55–59	\$217	\$452	\$281	\$495	55–59	\$241	\$502	\$313	\$550	55–59	\$266	\$553	\$345	\$606
60–64	\$278	\$557	\$344	\$616	60–64	\$309	\$619	\$382	\$685	60–64	\$340	\$681	\$420	\$754
65+	\$338	\$770	\$401	\$808	65+	\$375	\$855	\$445	\$897	65+	\$413	\$941	\$490	\$987
Deductible plans with HRA†														
\$30/\$1,500 PLAN with HRA														
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	\$93	\$254	\$210	\$306	<30	\$103	\$282	\$233	\$340	<30	\$113	\$310	\$256	\$374
30–39	\$110	\$293	\$222	\$343	30–39	\$122	\$326	\$246	\$382	30–39	\$134	\$358	\$270	\$419
40–49	\$148	\$302	\$232	\$384	40–49	\$165	\$336	\$258	\$427	40–49	\$181	\$370	\$283	\$470
50–54	\$198	\$411	\$271	\$455	50–54	\$220	\$457	\$301	\$506	50–54	\$242	\$502	\$331	\$556
55–59	\$246	\$511	\$319	\$560	55–59	\$273	\$568	\$354	\$623	55–59	\$300	\$624	\$389	\$684
60–64	\$315	\$630	\$389	\$697	60–64	\$350	\$700	\$433	\$775	60–64	\$385	\$770	\$476	\$852
65+	\$382	\$871	\$453	\$914	65+	\$424	\$967	\$503	\$1,014	65+	\$467	\$1,065	\$554	\$1,117
\$30/\$2,500 PLAN with HRA														
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	\$83	\$227	\$188	\$274	<30	\$92	\$252	\$209	\$304	<30	\$101	\$277	\$229	\$334
30–39	\$98	\$262	\$198	\$307	30–39	\$109	\$291	\$220	\$341	30–39	\$120	\$321	\$242	\$376
40–49	\$133	\$271	\$208	\$344	40–49	\$147	\$300	\$230	\$381	40–49	\$162	\$331	\$253	\$421
50–54	\$177	\$368	\$242	\$407	50–54	\$197	\$409	\$270	\$453	50–54	\$217	\$450	\$297	\$498
55–59	\$220	\$457	\$285	\$501	55–59	\$244	\$508	\$316	\$557	55–59	\$269	\$559	\$349	\$613
60–64	\$282	\$564	\$349	\$624	60–64	\$313	\$627	\$387	\$694	60–64	\$345	\$690	\$426	\$763
65+	\$342	\$780	\$406	\$818	65+	\$380	\$866	\$451	\$908	65+	\$418	\$953	\$496	\$1,000

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

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.

*Risk adjustment factor

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

\$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)	PHCS providers (PPO)	Nonparticipating providers (out-of-network)
		MEMBER PAYS	MEMBER PAYS	MEMBER PAYS
MEDICAL CALENDAR-YEAR DEDUCTIBLE Individual/Family	\$0	\$0	\$500/\$1,000 ¹	
PHARMACY CALENDAR-YEAR DEDUCTIBLE	\$250 for brand prescriptions	\$0	\$0	\$0
ANNUAL OUT-OF-POCKET MAXIMUM² (calendar year)	\$3,000 individual \$6,000 family	\$3,000 individual \$6,000 family	\$3,000 individual ³ \$9,000 family ³	\$6,000 individual ³ \$18,000 family ³
IN THE MEDICAL OFFICE				
Office visits	\$30	\$35	30% ⁴	50% ⁴
Preventive physical, vision, and hearing exams	\$30	\$35	Not covered	Not covered
Maternity/prenatal care ⁵	\$0	\$0	30% ⁴	50% ⁴
Well-child preventive care visits	\$0 ⁶	\$0 ⁶	30% ⁴	50% ⁴
Immunizations	\$0	\$0	Not covered	Not covered
Allergy injections	\$5	\$5	Not covered	Not covered
Infertility services	Not covered	Not covered ⁷	Not covered ⁷	Not covered ⁷
Occupational, physical, and speech therapy	\$30	\$35	30% ⁴ (combined 60-day limit per calendar year)	50% ⁴
Lab and imaging	\$10	\$10	30% ⁴	50% ⁴
MRI/CT/PET	\$50	\$50	30% ⁴	50% ⁴
Outpatient surgery	\$100	\$100	30% ⁴	50% ⁴
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 (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies) ⁸	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies) ⁸	Obtained at participating MedCare pharmacies ⁹	
Generic	\$10 ¹⁰	\$10 ¹⁰	\$15	Not covered
Brand	\$35 (after pharmacy deductible)	\$35	\$35	Not covered
Most nonformulary	Not covered	\$40	\$40	Not covered
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies	\$200 per day	\$200 per day	30% ⁴	50% ⁴
Skilled nursing facility care	\$0 (100-day limit per benefit period)	\$0 (100-day limit per benefit period)	30% ⁴ (combined 60-day limit per calendar year)	50% ⁴
MENTAL HEALTH SERVICES¹¹				
In the medical office (up to 20 visits per calendar year)	\$30 individual therapy \$15 group therapy	\$35 individual therapy \$17 group therapy	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 therapy \$5 group therapy	\$35 individual therapy \$5 group therapy	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) ¹²				
DME used during a covered stay in a Plan hospital or a skilled nursing facility	50%	\$0	30% ⁴ (combined \$2,000 maximum per calendar year)	50% ⁴
DME used in the home	Not covered	Not covered	30% ⁴ (combined \$2,000 maximum per calendar year)	50% ⁴
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% ^{4,13}	20% ^{4,13}
Hospice care	\$0	\$0	30% ⁴ (combined 180-day limit per calendar year)	50% ⁴

See footnotes and other important information on page 8.

RATE AREA 1

\$35 POS Plan

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

16 to 50 enrolling employees RAF* .90					6 to 15 enrolling employees RAF* 1.00					5 or fewer enrolling employees RAF* 1.10				
HMO OPTION 30														
Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$147	\$410	\$403	\$570	<30	\$163	\$455	\$447	\$633	<30	\$179	\$500	\$492	\$696
30-39	\$162	\$440	\$414	\$630	30-39	\$180	\$489	\$460	\$700	30-39	\$198	\$538	\$506	\$770
40-49	\$209	\$481	\$397	\$635	40-49	\$232	\$534	\$441	\$705	40-49	\$255	\$587	\$485	\$775
50-54	\$272	\$565	\$449	\$722	50-54	\$302	\$628	\$498	\$803	50-54	\$332	\$690	\$548	\$882
55-59	\$344	\$722	\$514	\$830	55-59	\$382	\$802	\$571	\$922	55-59	\$420	\$882	\$628	\$1,014
60-64	\$424	\$805	\$567	\$940	60-64	\$471	\$895	\$630	\$1,045	60-64	\$518	\$984	\$693	\$1,149
65+	\$481	\$1,039	\$723	\$1,142	65+	\$534	\$1,154	\$803	\$1,269	65+	\$587	\$1,269	\$883	\$1,395
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	Age	EE only	EE+S	EE+C	EE+S+C
<30	\$256	\$726	\$660	\$945	<30	\$285	\$807	\$734	\$1,050	<30	\$313	\$887	\$807	\$1,155
30-39	\$294	\$806	\$688	\$1,059	30-39	\$327	\$896	\$765	\$1,177	30-39	\$359	\$985	\$841	\$1,294
40-49	\$384	\$854	\$673	\$1,099	40-49	\$427	\$949	\$748	\$1,221	40-49	\$470	\$1,044	\$824	\$1,343
50-54	\$506	\$1,055	\$789	\$1,285	50-54	\$562	\$1,172	\$877	\$1,427	50-54	\$619	\$1,290	\$965	\$1,571
55-59	\$634	\$1,331	\$913	\$1,516	55-59	\$704	\$1,479	\$1,014	\$1,685	55-59	\$775	\$1,627	\$1,116	\$1,853
60-64	\$797	\$1,544	\$1,027	\$1,748	60-64	\$886	\$1,716	\$1,142	\$1,943	60-64	\$975	\$1,888	\$1,257	\$2,138
65+	\$964	\$2,126	\$1,281	\$2,219	65+	\$1,072	\$2,363	\$1,424	\$2,467	65+	\$1,179	\$2,599	\$1,566	\$2,713

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

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.

*Risk adjustment factor

FOOTNOTES

- 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 \$2,000,000 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.
- ⁴Based on maximum allowable charge
- ⁵Scheduled prenatal visits and the first postpartum visit
- ⁶Covered by Kaiser Permanente Plan providers (HMO) only to age 23 months or younger
- ⁷In 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.
- ⁸A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.
- ⁹Participating 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.
- ¹⁰This service is not subject to a deductible.
- ¹¹Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.
- ¹²Please refer to the *Evidence of Coverage* for more information; most DME is not covered.
- ¹³Home 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.

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.

HMO exclusions and limitations

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

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. 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.

KPIC contracts with PHCS. Together they are dedicated to delivering competitively priced quality health care for small businesses.

PHCS and nonparticipating provider 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.

Rate Area 1

Below is a listing of all ZIP codes within Rate Area 1.

The following counties are entirely within Rate Area 1:

San Francisco and San Mateo.

Portions of the following counties are also within Rate Area 1:

Alameda, Contra Costa, Santa Clara, and Santa Cruz.

94002	94177	94643	95035–95038
94003	94188	94649	95042
94005	94199	94659–94662	95044
94010–94031	94301–94310	94666	95046
94035	94401–94409	94701–94710	95050–95056
94037–94045	94497	94712	95070
94059–94067	94501	94720	95071
94070	94502	94801–94808	95101–95103
94071	94536–94546	94820	95106
94074	94550–94552	94850	95108–95142
94080	94555	94875	95148
94083	94557	95002	95150–95161
94085–94090	94560	95008	95164
94096	94566	95009	95170–95173
94098	94568	95011	95190–95194
94099	94577–94580	95013–95015	95196
94101–94112	94586–94588	95020	
94114–94147	94601–94615	95021	
94150–94172	94617–94625	95026	
94175	94627	95030–95033	



**Quick
guide**

Copayment

This is the fixed amount members must pay when they receive a prescription or covered service.

Deductible

In a deductible plan, this is the set amount members must pay in a calendar year before Kaiser Permanente begins to cover certain medical costs. Some plans have separate medical and pharmacy deductibles.

Generic and brand prescriptions

Generic medications are less expensive but chemically identical copies of their brand-name equivalents.

Out-of-pocket maximum

This is the highest amount members would have to pay for covered health care services in a calendar year.

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