

FOR OUR SMALL BUSINESS GROUPS

Effective July–December 2006

Rate Area 2

Plan highlights and rates

2006 SMALL BUSINESS

For new groups

Contents

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 2

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	\$130	\$363	\$357	\$505	<30	\$144	\$403	\$396	\$561	<30	\$159	\$444	\$436	\$618
30-39	\$143	\$389	\$366	\$557	30-39	\$159	\$433	\$407	\$620	30-39	\$175	\$476	\$448	\$682
40-49	\$185	\$426	\$352	\$562	40-49	\$206	\$474	\$391	\$625	40-49	\$226	\$520	\$430	\$686
50-54	\$241	\$501	\$397	\$640	50-54	\$268	\$557	\$442	\$712	50-54	\$294	\$612	\$485	\$782
55-59	\$304	\$639	\$455	\$735	55-59	\$338	\$710	\$505	\$817	55-59	\$372	\$781	\$556	\$898
60-64	\$375	\$713	\$502	\$832	60-64	\$417	\$792	\$558	\$925	60-64	\$459	\$872	\$614	\$1,018
65+	\$426	\$920	\$640	\$1,011	65+	\$473	\$1,022	\$711	\$1,124	65+	\$520	\$1,124	\$782	\$1,236
\$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	\$154	\$431	\$423	\$600	<30	\$171	\$478	\$470	\$666	<30	\$189	\$527	\$518	\$733
30-39	\$170	\$463	\$435	\$663	30-39	\$189	\$514	\$484	\$736	30-39	\$208	\$566	\$532	\$810
40-49	\$220	\$506	\$418	\$668	40-49	\$244	\$562	\$464	\$742	40-49	\$269	\$619	\$511	\$817
50-54	\$286	\$595	\$472	\$761	50-54	\$318	\$661	\$524	\$845	50-54	\$350	\$727	\$577	\$929
55-59	\$362	\$760	\$541	\$874	55-59	\$402	\$844	\$601	\$971	55-59	\$442	\$928	\$661	\$1,067
60-64	\$446	\$847	\$597	\$989	60-64	\$496	\$942	\$663	\$1,100	60-64	\$545	\$1,035	\$729	\$1,208
65+	\$506	\$1,093	\$761	\$1,202	65+	\$562	\$1,215	\$845	\$1,336	65+	\$618	\$1,336	\$929	\$1,469
\$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	\$180	\$503	\$494	\$700	<30	\$200	\$559	\$549	\$778	<30	\$220	\$614	\$604	\$855
30-39	\$199	\$540	\$508	\$773	30-39	\$221	\$600	\$565	\$859	30-39	\$243	\$660	\$621	\$945
40-49	\$257	\$591	\$488	\$780	40-49	\$285	\$656	\$542	\$866	40-49	\$314	\$722	\$596	\$953
50-54	\$334	\$694	\$551	\$887	50-54	\$371	\$771	\$612	\$986	50-54	\$408	\$848	\$673	\$1,084
55-59	\$422	\$886	\$631	\$1,019	55-59	\$469	\$985	\$701	\$1,133	55-59	\$516	\$1,083	\$771	\$1,246
60-64	\$520	\$988	\$696	\$1,153	60-64	\$578	\$1,098	\$773	\$1,282	60-64	\$636	\$1,208	\$851	\$1,410
65+	\$590	\$1,275	\$887	\$1,402	65+	\$656	\$1,417	\$986	\$1,558	65+	\$721	\$1,559	\$1,084	\$1,714
\$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	\$195	\$545	\$536	\$759	<30	\$217	\$606	\$596	\$843	<30	\$239	\$667	\$656	\$928
30-39	\$216	\$587	\$552	\$840	30-39	\$240	\$652	\$613	\$933	30-39	\$264	\$717	\$674	\$1,026
40-49	\$278	\$640	\$529	\$845	40-49	\$309	\$711	\$587	\$939	40-49	\$340	\$783	\$646	\$1,033
50-54	\$362	\$753	\$597	\$963	50-54	\$403	\$837	\$664	\$1,070	50-54	\$443	\$921	\$730	\$1,177
55-59	\$458	\$962	\$685	\$1,106	55-59	\$509	\$1,069	\$761	\$1,229	55-59	\$560	\$1,176	\$837	\$1,352
60-64	\$565	\$1,073	\$756	\$1,253	60-64	\$627	\$1,191	\$839	\$1,390	60-64	\$690	\$1,311	\$923	\$1,530
65+	\$640	\$1,384	\$962	\$1,521	65+	\$712	\$1,538	\$1,070	\$1,691	65+	\$783	\$1,692	\$1,177	\$1,860
\$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	\$242	\$676	\$665	\$941	<30	\$269	\$751	\$739	\$1,045	<30	\$296	\$826	\$813	\$1,149
30-39	\$267	\$726	\$683	\$1,039	30-39	\$297	\$807	\$759	\$1,155	30-39	\$327	\$888	\$835	\$1,271
40-49	\$345	\$794	\$655	\$1,048	40-49	\$383	\$881	\$728	\$1,163	40-49	\$422	\$970	\$801	\$1,280
50-54	\$449	\$933	\$740	\$1,193	50-54	\$499	\$1,037	\$823	\$1,325	50-54	\$549	\$1,141	\$905	\$1,458
55-59	\$567	\$1,191	\$848	\$1,370	55-59	\$630	\$1,323	\$942	\$1,522	55-59	\$693	\$1,456	\$1,036	\$1,675
60-64	\$700	\$1,329	\$936	\$1,551	60-64	\$777	\$1,476	\$1,039	\$1,723	60-64	\$855	\$1,624	\$1,144	\$1,896
65+	\$793	\$1,714	\$1,192	\$1,884	65+	\$882	\$1,906	\$1,326	\$2,095	65+	\$970	\$2,096	\$1,458	\$2,304

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 2

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	\$106	\$291	\$240	\$351	<30	\$118	\$323	\$267	\$389	<30	\$130	\$356	\$294	\$429
30–39	\$126	\$336	\$254	\$393	30–39	\$140	\$373	\$282	\$437	30–39	\$153	\$410	\$309	\$480
40–49	\$170	\$347	\$266	\$441	40–49	\$189	\$385	\$295	\$489	40–49	\$208	\$424	\$325	\$539
50–54	\$227	\$471	\$311	\$521	50–54	\$252	\$523	\$345	\$579	50–54	\$277	\$575	\$379	\$637
55–59	\$282	\$586	\$365	\$642	55–59	\$313	\$651	\$406	\$714	55–59	\$344	\$716	\$446	\$785
60–64	\$361	\$722	\$446	\$799	60–64	\$401	\$802	\$496	\$887	60–64	\$441	\$883	\$545	\$977
65+	\$438	\$998	\$520	\$1,047	65+	\$486	\$1,109	\$577	\$1,163	65+	\$535	\$1,220	\$635	\$1,280
\$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	\$86	\$236	\$195	\$284	<30	\$96	\$263	\$217	\$317	<30	\$106	\$290	\$239	\$349
30–39	\$102	\$273	\$206	\$320	30–39	\$113	\$303	\$228	\$355	30–39	\$125	\$334	\$252	\$391
40–49	\$138	\$282	\$216	\$358	40–49	\$153	\$313	\$239	\$398	40–49	\$169	\$344	\$264	\$437
50–54	\$184	\$382	\$252	\$423	50–54	\$205	\$425	\$281	\$470	50–54	\$225	\$467	\$308	\$517
55–59	\$229	\$476	\$297	\$522	55–59	\$254	\$528	\$329	\$579	55–59	\$280	\$582	\$363	\$638
60–64	\$293	\$587	\$362	\$649	60–64	\$326	\$652	\$403	\$721	60–64	\$358	\$717	\$443	\$793
65+	\$356	\$811	\$422	\$851	65+	\$395	\$901	\$469	\$945	65+	\$435	\$991	\$516	\$1,040
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	\$98	\$268	\$221	\$323	<30	\$109	\$298	\$246	\$359	<30	\$119	\$327	\$270	\$394
30–39	\$115	\$308	\$233	\$361	30–39	\$128	\$342	\$259	\$400	30–39	\$141	\$377	\$285	\$441
40–49	\$156	\$318	\$244	\$404	40–49	\$173	\$353	\$271	\$449	40–49	\$191	\$389	\$299	\$494
50–54	\$208	\$432	\$285	\$478	50–54	\$232	\$481	\$318	\$532	50–54	\$255	\$529	\$349	\$586
55–59	\$259	\$538	\$336	\$590	55–59	\$287	\$597	\$372	\$654	55–59	\$316	\$657	\$410	\$720
60–64	\$332	\$664	\$410	\$735	60–64	\$368	\$737	\$455	\$816	60–64	\$405	\$811	\$501	\$897
65+	\$402	\$917	\$477	\$962	65+	\$447	\$1,019	\$530	\$1,069	65+	\$492	\$1,121	\$584	\$1,176
\$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	\$87	\$239	\$197	\$288	<30	\$97	\$266	\$220	\$321	<30	\$107	\$293	\$242	\$353
30–39	\$103	\$276	\$208	\$323	30–39	\$115	\$307	\$232	\$359	30–39	\$126	\$337	\$255	\$395
40–49	\$140	\$285	\$219	\$362	40–49	\$155	\$316	\$243	\$402	40–49	\$171	\$349	\$267	\$443
50–54	\$186	\$387	\$255	\$428	50–54	\$207	\$430	\$284	\$476	50–54	\$228	\$473	\$312	\$524
55–59	\$232	\$482	\$301	\$528	55–59	\$257	\$535	\$333	\$586	55–59	\$283	\$588	\$367	\$645
60–64	\$297	\$594	\$367	\$657	60–64	\$330	\$660	\$408	\$730	60–64	\$363	\$726	\$449	\$803
65+	\$360	\$821	\$427	\$861	65+	\$400	\$912	\$475	\$957	65+	\$440	\$1,003	\$522	\$1,052

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	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	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 2

\$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	\$154	\$431	\$423	\$600	<30	\$171	\$478	\$470	\$666	<30	\$189	\$527	\$518	\$733
30-39	\$170	\$463	\$435	\$663	30-39	\$189	\$514	\$484	\$736	30-39	\$208	\$566	\$532	\$810
40-49	\$220	\$506	\$418	\$668	40-49	\$244	\$562	\$464	\$742	40-49	\$269	\$619	\$511	\$817
50-54	\$286	\$595	\$472	\$761	50-54	\$318	\$661	\$524	\$845	50-54	\$350	\$727	\$577	\$929
55-59	\$362	\$760	\$541	\$874	55-59	\$402	\$844	\$601	\$971	55-59	\$442	\$928	\$661	\$1,067
60-64	\$446	\$847	\$597	\$989	60-64	\$496	\$942	\$663	\$1,100	60-64	\$545	\$1,035	\$729	\$1,208
65+	\$506	\$1,093	\$761	\$1,202	65+	\$562	\$1,215	\$845	\$1,336	65+	\$618	\$1,336	\$929	\$1,469
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	\$270	\$764	\$696	\$995	<30	\$300	\$849	\$773	\$1,105	<30	\$330	\$934	\$850	\$1,216
30-39	\$309	\$848	\$724	\$1,114	30-39	\$344	\$943	\$805	\$1,239	30-39	\$378	\$1,037	\$886	\$1,363
40-49	\$404	\$899	\$708	\$1,157	40-49	\$449	\$999	\$787	\$1,285	40-49	\$494	\$1,099	\$866	\$1,414
50-54	\$533	\$1,111	\$831	\$1,353	50-54	\$592	\$1,234	\$923	\$1,503	50-54	\$651	\$1,357	\$1,015	\$1,653
55-59	\$667	\$1,401	\$961	\$1,596	55-59	\$741	\$1,557	\$1,068	\$1,774	55-59	\$815	\$1,712	\$1,174	\$1,950
60-64	\$839	\$1,626	\$1,082	\$1,841	60-64	\$933	\$1,807	\$1,203	\$2,046	60-64	\$1,026	\$1,987	\$1,322	\$2,250
65+	\$1,015	\$2,238	\$1,348	\$2,336	65+	\$1,128	\$2,487	\$1,498	\$2,596	65+	\$1,241	\$2,736	\$1,648	\$2,856

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 2

Below is a listing of all ZIP codes within Rate Area 2.

The following counties are entirely within Rate Area 2:

Napa and Solano.

Portions of the following counties are also within Rate Area 2:

Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Placer, Sacramento, San Joaquin, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba.

93230	93720–93722	94256–94259	94922–94931	95316	95442	95686–95688
93232	93724–93729	94261–94263	94933	95319	95444	95690–95698
93242	93740	94267–94269	94937–94942	95320	95446	95703
93601	93741	94271	94945–94957	95323	95448	95722
93602	93744	94273	94960	95326	95450	95736
93604	93745	94274	94963–94966	95328–95330	95452	95741–95743
93606	93747	94277–94280	94970–94979	95336	95462	95746
93607	93750	94282–94291	94998	95337	95465	95747
93609	93755	94293–94299	94999	95350–95358	95471–95473	95757–95759
93611	93760	94503	95201–95213	95360	95476	95762
93612–93614	93761	94506–94531	95215	95361	95486	95763
93616	93764	94533–94535	95219	95363	95487	95765
93618	93765	94547–94549	95220	95366–95368	95492	95776
93619	93771–93780	94553	95227	95376–95378	95602–95605	95798
93623–93627	93784	94556	95230	95380–95382	95607–95621	95799
93630	93786	94558	95231	95385–95387	95623–95626	95812–95838
93631	93790–93794	94559	95234	95391	95628	95840–95843
93637–93639	93844	94561–94565	95236	95397	95630	95851–95853
93643–93646	93888	94567	95237	95401–95409	95632–95635	95857
93648–93654	94203–94209	94569–94576	95240–95242	95416	95638	95860
93656	94211	94581–94583	95253	95419	95639–95641	95864–95867
93657	94229	94585	95258	95421	95645	95887
93660	94230	94589–94592	95267	95425	95648	95894
93662	94232	94595–94599	95269	95430	95650–95652	95899
93666–93669	94234–94237	94901	95296	95431	95655	95903
93673	94239	94903	95297	95433	95658–95664	95961
93675	94240	94904	95304	95436	95667–95674	
93701–93712	94243–94250	94912–94915	95307	95439	95676–95678	
93714–93718	94252–94254	94920	95313	95441	95680–95683	

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.

Quick
guide

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