Plan highlights

For effective dates January 1–June 1, 2012

KAISER PERMANENTE®

Notes for all plans

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

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plans and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic/acupuncture plan is administered by American Specialty Health Plans of California, Inc. The PPO chiropractic/acupuncture plan is administered by Private Healthcare Systems.

This booklet is a summary only.

The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure is not intended for use as a benefit summary, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.

CONTENTS

[1]Tax references relate to federal income tax only. Consult with your financial or tax adviser for more information.

KAISER PERMANENTE
COPAYMENT PLANS
PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

MOST POPULAR COPAYMENT PLAN

FEATURES	$5 PLAN MEMBER PAYS	$15 PLAN MEMBER PAYS	$20 PLAN MEMBER PAYS	$30 PLAN MEMBER PAYS	$50 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE	$0	$0	$0	$0	$0
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A	$250 for brand prescription	$250 for brand prescription
ANNUAL OUT-OF-POCKET MAXIMUM[1]					
Self-only enrollment/Family enrollment	$1,500/$3,000	$2,500/$5,000	$2,500/$5,000	$3,000/$6,000	$3,500/$7,000
IN THE MEDICAL OFFICE					
Office visits	$5	$15	$20	$30	$50
Preventive exams	$0	$0	$0	$0	$0
Maternity/Prenatal care[2]	$0	$0	$0	$0	$0
Well-child preventive care visits[3]	$0	$0	$0	$0	$0
Vaccines (immunizations)	$0	$0	$0	$0	$0
Allergy injections	$0	$5	$5	$5	$5
Infertility services	50%	50%	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$5	$15	$20	$30	$50
Most labs and imaging	$10	$10	$10	$10	$10
MRI/CT/PET	$50	$50	$50	$50	$50
Outpatient surgery	$5 per procedure	$100 per procedure	$150 per procedure	$200 per procedure	$250 per procedure
EMERGENCY SERVICES					
Emergency Department visits (waived if admitted directly to hospital)	$100	$100	$100	$100	$150
Ambulance	$75	$75	$75	$75	$300
PRESCRIPTIONS[4]	(up to a 100-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 100-day supply)	(up to a 100-day supply)
Generic[5]	$5	$10	$10	$10	$10
Brand-name	$15[5]	$25[5]	$30[5]	$35 (after pharmacy deductible)	$35 (after pharmacy deductible)
HOSPITAL CARE					
Physicians' services, room and board, tests, medications, supplies, therapies	$0	$200 per day	$300 per day	$400 per day	$500 per day
Skilled nursing facility care (up to 100 days per benefit period)	$0	$0	$0	$0	$0
MENTAL HEALTH SERVICES					
In the medical office	$5 individual $2 group	$15 individual $7 group	$20 individual $10 group	$30 individual $15 group	$50 individual $25 group
In the hospital	$0	$200 per day	$300 per day	$400 per day	$500 per day
CHEMICAL DEPENDENCY SERVICES					
In the medical office	$5 individual	$15 individual	$20 individual	$30 individual	$50 individual
In the hospital (detoxification only)	$0	$200 per day	$300 per day	$400 per day	$500 per day
OTHER					
Certain durable medical equipment (DME)	20%[7]	20%[7]	20%[7]	Not covered[6]	Not covered[6]
Prosthetics, orthotics, and footwear	$0[8]	$0[8]	$0[8]	Not covered[6]	Not covered[6]
Optical (eyewear)	$150 allowance[10]	$150 allowance[10]	Not covered[9]	Not covered[9]	Not covered[9]
Vision exam	$0	$0	$0	$0	$0
Home health care (up to 100 two-hour visits per calendar year)	$0	$0	$0	$0	$0
Hospice care	$0	$0	$0	$0	$0

Kaiser Permanente plans do not include a pre-existing condition clause.
Preventive services on this plan are available at no cost share. For a complete list of preventive services please refer to the *Evidence of Coverage* or businessnet.kp.org.

[1]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*).
[2]Scheduled prenatal visits and the first postpartum visit
[3]Well-child visits through age 23 months
[4]Prescription 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.
[5]The deductible does not apply to this service.
[6]Please refer to the *Evidence of Coverage* for more information on durable medical equipment and prosthetics and orthotics. Most durable medical equipment is not covered.
[7]The maximum allowable amount for durable medical equipment is $2,000.
[8]There is no maximum amount for prosthetics and orthotics.
[9]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.
[10]Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

KAISER PERMANENTE
DEDUCTIBLE HMO PLANS
PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

FEATURES	$30/$1,000 PLAN MEMBER PAYS	MOST POPULAR DEDUCTIBLE PLAN $30/$1,500 PLAN MEMBER PAYS	$40/$2,000 PLAN MEMBER PAYS	$40/$3,000 PLAN MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]				
Individual/Family	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]				
Individual/Family	$3,500/$7,000	$3,500/$7,000	$4,500/$9,000	$6,000/$12,000
IN THE MEDICAL OFFICE				
Office visits[3]	$30	$30	$40	$40
Preventive exams[3]	$0	$0	$0	$0
Maternity/Prenatal care[3,4]	$0	$0	$0	$0
Well-child preventive care visits[3,5]	$0	$0	$0	$0
Vaccines (immunizations)[3]	$0	$0	$0	$0
Allergy injections	$5 (after deductible)	$5 (after deductible)	$5 (after deductible)	$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$30 (after deductible)	$30 (after deductible)	$40 (after deductible)	$40 (after deductible)
Most labs and imaging	$10 (after deductible)	$10 (after deductible)	$10 (after deductible)	$10[3]
MRI/CT/PET	$50 (after deductible)	$50 (after deductible)	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	$250 per procedure (after deductible)	$250 per procedure (after deductible)	30% (after deductible)	30% (after deductible)
EMERGENCY SERVICES				
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)	30% (after deductible)
Ambulance	$75 (after deductible)	$75 (after deductible)	$100 (after deductible)	$100 (after deductible)
PRESCRIPTIONS[3,6]	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10	$10	$10	$10
Brand-name	$30	$30	$35	$35
HOSPITAL CARE				
Physicians' services, room and board, tests, medications, supplies, therapies	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)	30% per admission (after deductible)
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day (after deductible)	$50 per day (after deductible)	30% per admission (after deductible)	30% per admission (after deductible)
MENTAL HEALTH SERVICES				
In the medical office[3]	$30 (for individual therapy) $15 (for group therapy)	$30 (for individual therapy) $15 (for group therapy)	$40 (for individual therapy) $20 (for group therapy)	$40 (for individual therapy) $20 (for group therapy)
In the hospital	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)	30% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES				
In the medical office[3]	$30 (for individual therapy)	$30 (for individual therapy)	$40 (for individual therapy)	$40 (for individual therapy)
In the hospital (detoxification only)	$500 per day (after deductible)	$500 per day (after deductible)	30% per admission (after deductible)	30% per admission (after deductible)
OTHER				
Certain durable medical equipment (DME)[7]	Not covered	Not covered	Not covered	Not covered
Prosthetics, orthotics, and footwear[7]	Not covered	Not covered	Not covered	Not covered
Optical (eyewear)[8]	Not covered	Not covered	Not covered	Not covered
Vision exam[3]	$0	$0	$0	$0
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0	$0	$0
Hospice care[3]	$0	$0	$0	$0

Kaiser Permanente plans do not include a pre-existing condition clause.
Preventive services on this plan are available at no cost share. For a complete list of preventive services please refer to the *Evidence of Coverage* or businessnet.kp.org.

[1]This is an embedded plan. For a family of two or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.

[2]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*).

[3]For this service the deductible doesn't apply.

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]Prescription 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.

[7]Please refer to the *Evidence of Coverage* for more information on durable medical equipment and prosthetics and orthotics. Most durable medical equipment is not covered.

[8]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

KAISER PERMANENTE

HSA-QUALIFIED DEDUCTIBLE HMO PLANS

PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

FEATURES	$0/$2,000 PLAN W/HSA MEMBER PAYS	MOST POPULAR DEDUCTIBLE PLAN W/HSA $0/$2,700 PLAN W/HSA MEMBER PAYS	$30/$3,000 PLAN W/HSA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE			
Individual/Family	$2,000/$4,000[2]	$2,700/$5,450[1]	$3,000/$6,000[1]
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[3]			
Individual/Family	$3,500/$7,000[2]	$4,500/$9,000[1]	$5,950/$11,900[1]
IN THE MEDICAL OFFICE			
Office visits	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Preventive exams[4]	$0	$0	$0
Maternity/Prenatal care[4,5]	$0	$0	$0
Well-child preventive care visits[4,6]	$0	$0	$0
Vaccines (immunizations)[4]	$0	$0	$0
Allergy injections	$0 (after deductible)	$0 (after deductible)	$5 (after deductible)
Infertility services	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Most labs and imaging	$0 (after deductible)	$0 (after deductible)	$10 (after deductible)
MRI/CT/PET	$50 (after deductible)	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	$150 per procedure (after deductible)	$250 per procedure (after deductible)	30% (after deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	$100 (after deductible)	$100 (after deductible)	30% (after deductible)
Ambulance	$100 (after deductible)	$100 (after deductible)	$100 (after deductible)
PRESCRIPTIONS[7]	(up to a 30-day supply)	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10 (after deductible)	$10 (after deductible)	$10 (after deductible)
Brand-name	$30 (after deductible)	$30 (after deductible)	$30 (after deductible)
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$0 per admission (after deductible)	$0 per admission (after deductible)	30% per admission (after deductible)
MENTAL HEALTH SERVICES			
In the medical office	$0 (after deductible for individual therapy) $0 (after deductible for group therapy)	$0 (after deductible for individual therapy) $0 (after deductible for group therapy)	$30 (after deductible for individual therapy) $15 (after deductible for group therapy)
In the hospital	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office	$0 (after deductible for individual therapy)	$0 (after deductible for individual therapy)	$30 (after deductible for individual therapy)
In the hospital (detoxification only)	$300 per day (after deductible)	$450 per day (after deductible)	30% per admission (after deductible)
OTHER			
Certain durable medical equipment (DME)[8]	Not covered	Not covered	Not covered
Prosthetics, orthotics, and footwear[8]	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)
Optical (eyewear)[9]	Not covered	Not covered	Not covered
Vision exam	$0 (after deductible)	$0 (after deductible)	$30 (after deductible)
Home health care (up to 100 two-hour visits per calendar year)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)
Hospice care	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)

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

Preventive services on this plan are available at no cost share. For a complete list of preventive services please refer to the *Evidence of Coverage* or businessnet.kp.org.

[1]This is an embedded plan. For a family of two or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.

[2]This is an aggregate plan. For a family of two or more, the family deductible applies to the whole family. Once the family deductible is met (by one family member or combination of family members), the family becomes eligible for copayments or coinsurance. The same methodology applies to the out-of-pocket maximum.

[3]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*).

[4]The deductible does not apply to this service.

[5]Scheduled prenatal visits

[6]Well-child visits through age 23 months

[7]Prescription 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.

[8]Please refer to the *Evidence of Coverage* for more information on durable medical equipment and prosthetics and orthotics. Most durable medical equipment is not covered.

[9]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

KAISER PERMANENTE
DEDUCTIBLE HMO PLANS WITH HRA
PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

FEATURES	$30/$1,500 PLAN WITH HRA MEMBER PAYS	$30/$2,500 PLAN WITH HRA MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]		
Individual/Family	$1,500/$3,000	$2,500/$5,000
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]		
Individual/Family	$3,500/$7,000	$5,000/$10,000
IN THE MEDICAL OFFICE		
Office visits	$30 (after deductible)	$30 (after deductible)
Preventive exams[3]	$0	$0
Maternity/Prenatal care[3,4]	$0	$0
Well-child preventive care visits[3,5]	$0	$0
Vaccines (immunizations)[3]	$0	$0
Allergy injections	$0 (after deductible)	$0 (after deductible)
Infertility services	Not covered	Not covered
Occupational, physical, and speech therapy	$30 (after deductible)	$30 (after deductible)
Most labs and imaging	$10 (after deductible)	$10 (after deductible)
MRI/CT/PET	$50 (after deductible)	$50 (after deductible)
Outpatient surgery	20% (after deductible)	20% (after deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	20% (after deductible)	20% (after deductible)
Ambulance	$150 (after deductible)	$150 (after deductible)
PRESCRIPTIONS[3,6]	(up to a 30-day supply)	(up to a 30-day supply)
Generic	$10	$10
Brand-name	$30	$30
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies	20% per admission (after deductible)	20% per admission (after deductible)
Skilled nursing facility care	20% per admission (after deductible) (up to 100 days per benefit period)	20% per admission (after deductible) (up to 100 days per benefit period)
MENTAL HEALTH SERVICES		
In the medical office	$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	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)
In the hospital (detoxification only)	20% per admission (after deductible)	20% per admission (after deductible)
OTHER		
Certain durable medical equipment (DME)[7]	Not covered	Not covered
Prosthetics, orthotics, and footwear[7]	$0 (after deductible)	$0 (after deductible)
Optical (eyewear)[8]	Not covered	Not covered
Vision exam[3]	$0	$0
Home health care[3] (up to 100 two-hour visits per calendar year)	$0	$0
Hospice care[3]	$0	$0

Kaiser Permanente plans do not include a pre-existing condition clause.
Preventive services on this plan are available at no cost share. For a complete list of preventive services please refer to the *Evidence of Coverage* or businessnet.kp.org.
Employer is required to work with its own chosen third-party HRA administrator.

[1]This is an embedded plan. For a family of two or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.

[2]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*).

[3]The deductible does not apply to this service.

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]Prescription 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.

[7]Please refer to the *Evidence of Coverage* for more information on durable medical equipment and prosthetics and orthotics. Most durable medical equipment is not covered.

[8]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

KAISER PERMANENTE
$35 POS PLAN
PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

FEATURES	Kaiser Permanente Plan providers (HMO) (in-network) MEMBER PAYS	PHCS providers (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]	$0	$500 (individual)/$1,000 (family of 2)/$1,500 (family of 3+)	
PHARMACY CALENDAR-YEAR DEDUCTIBLE	N/A	N/A	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM[2,3]	$3,000 (individual)/ $6,000 (family of 2+)	$3,000 (individual)/$6,000 (family of 2)/$9,000 (family of 3+)[4]	$6,000 (individual)/$12,000 (family of 2)/$18,000 (family of 3+)[4]
IN THE MEDICAL OFFICE			
Office visits	$35	$45 (deductible waived)	50%
Routine adult physical exams	$0	$45[5] (deductible waived)	Not covered
Adult preventive screening services	$0	$45 (deductible waived)	50% (deductible waived)
Maternity/Prenatal care[6]	$0	$25 (deductible waived)	50%
Well-child preventive care visits	$0[7]	$25[8] (deductible waived)	50%[8]
Vaccines (immunizations)	$0	Not covered	Not covered
Allergy injections	$5	$25 (deductible waived)	50%
Infertility services[9]	Not covered	Not covered	Not covered
Occupational, physical, and speech therapy	$35	$45[10] (deductible waived)	50%[10]
Most labs and imaging	$10	30%	50%
MRI/CT/PET	$50	30%	50%
Outpatient surgery	$100	30%	50%[11]
EMERGENCY SERVICES			
Emergency Department visits (copay waived if admitted directly to hospital)	Covered as an HMO benefit, subject to a $100 copay, regardless of facility/hospital accessed		
EMERGENCY AMBULANCE SERVICES		Covered as an HMO benefit, subject to a $75 charge	
Medically necessary nonemergency ambulance service	$75	50%[12]	50%[12]
PRESCRIPTIONS[13] (up to a 100-day supply)	Obtained at Kaiser Permanente Plan pharmacies (including affiliated pharmacies)	Obtained at participating MedImpact pharmacies[14]	Obtained at non–Kaiser Permanente and non–MedImpact pharmacies
Generic	$10	$15	Not covered
Brand-name	$35	$40	Not covered
Nonformulary	$50	$60	Not covered
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies	$200 per day	30%	50%[16]
Skilled nursing facility care[15]	$0	30%	50%[16]
MENTAL HEALTH SERVICES			
In the medical office	$35 individual therapy	$45 per individual therapy visit (deductible waived)	50% per individual therapy visit
	$17 group therapy	$45 group therapy (deductible waived)	50% group therapy
In the hospital	$200 per day	30%	50%[16]
CHEMICAL DEPENDENCY SERVICES			
In the medical office	$35 individual therapy	$45 per individual therapy visit (deductible waived)	50% per individual therapy visit
	$5 group therapy	$45 group therapy (deductible waived)	50% group therapy
In the hospital	$200 per day	30%	50%[16]
OTHER			
Certain durable medical equipment (DME)[17]	$0	30%[18]	50%[18]
Prosthetics, orthotics, and special footwear[17]	$0	Not covered	Not covered
Optical (eyewear)	Not covered[19]	Not covered	Not covered
Vision exam	$0	Not covered	Not covered
Home health care	$0 (up to 100 two-hour visits per calendar year)	20%[20]	20%[20]
Hospice care	$0	30%[21]	50%[21]
MAXIMUM BENEFIT WHILE INSURED	None	$2 million[22]	

For your group to be eligible for the $35 POS Plan, the $40/$1,000 PPO Plan, or the $40/$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

See footnotes and other important information on pages 7 and 12.

Notes for the Kaiser Permanente $35 POS Plan

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

***Based on maximum allowable charge for covered services**
Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge **may be** less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

[1]Deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied.

[2]The annual out-of-pocket maximum (OOPM) is the limit to the total amount that an individual (self-only) or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage* and the *Certificate of Insurance*). A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

[3]Covered charges incurred to satisfy the out-of-pocket maximum at the PHCS network level will not be applicable toward satisfaction of the out-of-pocket maximum at the nonparticipating providers level. Likewise, covered charges applied to satisfy the out-of-pocket maximum at the nonparticipating providers level will not be applicable toward satisfaction of the out-of-pocket maximum at the PHCS network level.

[4]The family out-of-pocket maximum equals three times the individual out-of-pocket maximum for family contracts of three or more members. Family contracts with two members will require each member to satisfy the individual out-of-pocket maximum.

[5]Routine adult physical exams are limited to one exam every 12 months. Preventive lab tests, X-ray, and immunizations are covered as part of the preventive exam.

[6]Scheduled prenatal visits and the first postpartum visit.

[7]Well-child care is covered by Kaiser Permanente Plan providers (HMO) through age 23 months.

[8]Well-child care (ages 0 to 21) is exempt from deductibles from PHCS network providers and includes immunizations.

[9]In 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.

[10]All outpatient therapies are limited to 60 days per calendar year for services from PHCS network and nonparticipating providers combined.

[11]Kaiser Permanente Insurance Company (KPIC) pays a maximum of $4000 per procedure for outpatient surgery services from nonparticipating providers.

[12]The PHCS Provider Network does not contract for ambulance coverage. Therefore, ambulance coverage is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of $2,000 per calendar year for all KPIC-covered services.

[13]A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments. Nonformulary prescriptions that are not covered as an HMO benefit are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc.

[14]Participating MedImpact pharmacy copayments and deductibles are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the OOPM. Select prescription medications are excluded from coverage. Please consult your participating pharmacy directory for a current list of participating pharmacies.

[15]Care in a skilled nursing facility is limited to 100 days per benefit period.

[16]Kaiser Permanente Insurance Company pays a maximum of $600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

[17]Please refer to the *Evidence of Coverage* and the *Certificate of Insurance* for more information.

[18]Durable medical equipment benefit is limited to $2,000 maximum per calendar year for services from PHCS network and nonparticipating providers combined, excluding diabetic testing supplies and equipment.

[19]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional, or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.

[20]Home health care is limited to a maximum of 100 visits per calendar year combined for services provided by PHCS network and nonparticipating providers. Deductible amount is limited to a maximum of $50 per calendar year.

[21]Hospice care is limited to a 180-day maximum benefit while insured for services from PHCS network and nonparticipating providers combined.

[22]Maximum benefit while insured is $2 million combined for services provided by PHCS network and nonparticipating providers.

HMO exclusions and limitations

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

KAISER PERMANENTE

$40/$1,000 PPO INSURANCE PLAN

PLAN HIGHLIGHTS

For effective dates 1/1/12–6/1/12

FEATURES	PHCS network (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]	$1,000 (individual)/$2,000 (family of 2+)	
ANNUAL OUT-OF-POCKET MAXIMUM[1,2]	$5,000 (individual)/$10,000 (family of 2+)	$10,000 (individual)/$20,000 (family of 2+)
HOSPITAL CARE		
Room, board, and critical care units	30% (after deductible)	50%[3] (after deductible)
Imaging, including X-rays and lab tests	30% (after deductible)	50%[3] (after deductible)
Transplants	30% (after deductible)	50%[3] (after deductible)
Physician, surgeon, and surgical services	30% (after deductible)	50% (after deductible)
Nursing care, anesthesia, and inpatient prescribed drugs	30% (after deductible)	50%[3] (after deductible)
OUTPATIENT CARE		
Provider office visits	$40 copay[4,5]	50% (after deductible)
Routine adult physical exams	$0[5,6]	Not covered
Adult preventive screening services	$0[5]	50%[5]
Well-child preventive care visits (through age 21)[7]	$0[5]	50%[5]
Pediatric visits	$40 copay[4,5]	50% (after deductible)
Outpatient surgery	30% (after deductible)	50%[8] (after deductible)
Allergy testing visits	30% (after deductible)	50% (after deductible)
Allergy injection visits	30% (after deductible)	50% (after deductible)
Gynecological visits	$40 copay[4,5]	50% (after deductible)
Maternity/Scheduled prenatal care and first postpartum visit	30% (after deductible)	50% (after deductible)
Diagnostic imaging, including X-rays	30% (after deductible)	50% (after deductible)
Diagnostic lab tests	30% (after deductible)	50% (after deductible)
Eye exams for eyeglass prescriptions	Not covered	Not covered
Hearing screenings	$0[5]	Not covered
Occupational, physical, respiratory, and speech therapy visits[9]	30% (after deductible)	50% (after deductible)
Health education	$0[5]	Not covered
EMERGENCY SERVICES		
Emergency Department visits	$100 copay, then 30% (copay waived if admitted) (after deductible)	$100 copay, then 30% (copay waived if admitted) (after deductible)
Emergency ambulance service	50% (after deductible)	50% (after deductible)
Medically necessary nonemergency ambulance service[10]	50% (after deductible)	50% (after deductible)
PRESCRIPTIONS[11]	**MedImpact pharmacy[12]**	**Non–MedImpact pharmacy**
Brand-name deductible (pharmacy and mail order)	$200 deductible[4]	Not covered
Generic drugs	$15 copay[4] (maximum 30-day supply)	Not covered
Brand-name drugs	$35 copay[4] (maximum 30-day supply) (after brand-name drug deductible)	Not covered
Self-administered injectable drugs[13]	30%[4]	Not covered
Mail-order generic drugs	$30 copay[4] (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	$70 copay[4] (maximum 100-day supply)	Not covered
MENTAL HEALTH CARE		
Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child)	30% (after deductible)	50%[3] (after deductible)
Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	$40 copay[4,5]	50% (after deductible)
ALCOHOL AND CHEMICAL DEPENDENCY		
Inpatient hospitalization	30% (after deductible)	50%[3] (after deductible)
Outpatient visits	$40 copay[4,5]	50% (after deductible)
ADDITIONAL BENEFITS		
Care in a skilled nursing facility (60-day combined limit per Benefit period)	30% (after deductible)	50% (after deductible)[3]
Home health care (100 visits per calendar year)[14]	20% (after deductible)	20% (after deductible)
Hospice care (180-day combined maximum benefit while insured)	30% (after deductible)	50% (after deductible)
Infertility services[15]	30% (after deductible)	50% (after deductible)
Durable medical equipment (DME)[16]	30% (after deductible)	50% (after deductible)
Prosthetics, orthotics, and special footwear	30% (after deductible)	50% (after deductible)
Diabetic equipment and supplies[17]	30% (after deductible)	30% (after deductible)
MAXIMUM BENEFIT WHILE INSURED[18]	None	$5 milllion

For your group to be eligible for the $35 POS Plan, the $40/$1,000 PPO Plan, or the $40/$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

See footnotes and other important information on pages 9 and 12.

Notes for the Kaiser Permanente $40/$1,000 PPO Insurance Plan

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

***Based on maximum allowable charge for covered services**
Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge **may be** less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

[1] Calendar-year deductible amounts are combined for services provided by PHCS network and nonparticipating providers. Deductibles do not count toward satisfying the out-of-pocket maximum. This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

[2] Covered charges incurred toward satisfaction of the out-of-pocket maximum at the nonparticipating providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the PHCS network tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS network tier will not accumulate toward satisfaction of the out-of-pocket maximum on the nonparticipating providers tier.

[3] Kaiser Permanente Insurance Company (KPIC) pays a maximum of $600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

[4] Brand-name drug deductible, copayment, and coinsurance paid for physician office visit or paid for prescriptions filled at participating pharmacies are not subject to, nor do they contribute toward, satisfaction of either the calendar-year deductible or the out-of-pocket maximum.

[5] For this service a deductible does not apply.

[6] Routine adult physical exams are limited to one exam every 12 months. Preventive lab tests, X-ray, and immunizations are covered as part of the preventive exam.

[7] Well-child preventive care is exempt from deductibles and includes immunizations.

[8] Kaiser Permanente Insurance Company pays a maximum of $400 per procedure for outpatient surgery services from nonparticipating providers.

[9] All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

[10] The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of $2,000 per calendar year for all services.

[11] Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the patient requests a brand-name drug and a generic version is available.

[12] MedImpact pharmacy copayments are not subject to, nor do they contribute toward satisfaction of, the calendar-year deductible or the out-of-pocket maximum. Select prescription drugs are excluded from coverage.

[13] Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.

[14] Combined maximum deductible of $50 per calendar year

[15] Benefits payable for treatment of infertility are limited to $1,000 per calendar year combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.

[16] Certain durable medical equipment and supplies are limited to a combined maximum benefit of $2,000 per calendar year for services from PHCS network and nonparticipating providers, excluding diabetic testing supplies and equipment.

[17] Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pump, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of $2,000 per calendar year.

[18] Maximum benefit while insured applies to covered charges from nonparticipating providers only.

KAISER PERMANENTE

For effective dates 1/1/12–6/1/12

$40/$2,500 PPO INSURANCE PLAN WITH HSA OPTION

PLAN HIGHLIGHTS

FEATURES	PHCS network (PPO)* MEMBER PAYS	Nonparticipating providers (out-of-network)* MEMBER PAYS
CALENDAR-YEAR DEDUCTIBLE[1]	$2,500 (individual)/$5,000 (family of 2+)	$3,500 (individual)/$7,000 (family of 2+)
ANNUAL OUT-OF-POCKET MAXIMUM[2]	$5,000 (individual)/$10,000 (family of 2+)	$10,000 (individual)/$20,000 (family of 2+)
HOSPITAL CARE		
Room, board, and critical care units	30% (after deductible)	50%[3] (after deductible)
Imaging, including X-rays and lab tests	30% (after deductible)	50%[3] (after deductible)
Transplants	30% (after deductible)	50%[3] (after deductible)
Physician, surgeon, and surgical services	30% (after deductible)	50% (after deductible)
Nursing care, anesthesia, and inpatient prescribed drugs	30% (after deductible)	50%[3] (after deductible)
OUTPATIENT CARE		
Provider office visits	$40 copay (after deductible)	50% (after deductible)
Routine adult physical exams	$0[4,5]	Not covered
Adult preventive screening services	$0[4]	50%[4]
Well-child preventive care visits (through age 21)[6]	$0[4]	50%[4]
Pediatric visits	$40 copay (after deductible)	50% (after deductible)
Outpatient surgery	30% (after deductible)	50%[7] (after deductible)
Allergy testing visits	30% (after deductible)	50% (after deductible)
Allergy injection visits	30% (after deductible)	50% (after deductible)
Gynecological visits	$40 copay (after deductible)	50% (after deductible)
Maternity/Scheduled prenatal care and first postpartum visit	30% (after deductible)	50% (after deductible)
Diagnostic imaging, including X-rays	30% (after deductible)	50% (after deductible)
Diagnostic lab tests	30% (after deductible)	50% (after deductible)
Eye exams for eyeglass prescriptions	Not covered	Not covered
Hearing screenings	$0[4]	Not covered
Occupational, physical, respiratory, and speech therapy visits[8]	30% (after deductible)	50% (after deductible)
Health education	$0[4]	50% (after deductible)
EMERGENCY SERVICES		
Emergency Department visits	$100 copay, then 30% (copay waived if admitted) (after deductible)	$100 copay, then 30% (copay waived if admitted) (after deductible)
Emergency ambulance service	50% (after deductible)	50% (after deductible)
Medically necessary nonemergency ambulance service[9]	50% (after deductible)	50% (after deductible)
Nonemergency urgent care	30% (after deductible)	50% (after deductible)
PRESCRIPTIONS[10]	**MedImpact pharmacy[11]** (after deductible)	**Non–MedImpact pharmacy**
Generic drugs	$15 copay (maximum 30-day supply)	Not covered
Brand-name drugs	$35 copay (maximum 30-day supply)	Not covered
Self-administered injectable medications[12]	30%	Not covered
Mail-order generic drugs	$30 copay (maximum 100-day supply)	Not covered
Mail-order brand-name drugs	$70 copay (maximum 100-day supply)	Not covered
MENTAL HEALTH CARE		
Inpatient hospitalization (Including severe mental illness and serious emotional disturbances of a child)	30% (after deductible)	50%[3] (after deductible)
Outpatient visits (Including severe mental illness and serious emotional disturbances of a child)	$40 copay (after deductible)	50% (after deductible)
ALCOHOL AND CHEMICAL DEPENDENCY		
Inpatient hospitalization	30% (after deductible)	50%[3] (after deductible)
Outpatient visits	$40 copay (after deductible)	50% (after deductible)
ADDITIONAL BENEFITS		
Care in a skilled nursing facility (60-day combined limit per Benefit period)	30% (after deductible)	50% (after deductible)[3]
Home health care (100 visits per calendar year)	20% (after deductible)	20% (after deductible)
Hospice care (180-day combined maximum benefit while insured)	30% (after deductible)	Not covered
Infertility services[13]	30% (after deductible)	50% (after deductible)
Durable medical equipment (DME)[14]	30% (after deductible)	50% (after deductible)
Prosthetics, orthotics, and special footwear	30% (after deductible)	50% (after deductible)
Diabetic equipment and supplies[15]	30% (after deductible)	30% (after deductible)
MAXIMUM BENEFIT WHILE INSURED[16]	None	$5 milllion

For your group to be eligible for the $35 POS Plan, the $40/$1,000 PPO Plan, or the $40/$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

See footnotes and other important information on pages 11 and 12.

Notes for the Kaiser Permanente $40/$2,500 PPO Insurance Plan with HSA Option

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

***Based on maximum allowable charge for covered services**
Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge **may be** less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

[1]Calendar-year deductible amounts are separate for services provided by PHCS network and nonparticipating providers. Covered charges applied toward the satisfaction of the calendar-year deductible may also be applied toward the satisfaction of the out-of-pocket maximum.

[2]Out-of-pocket maximums are separate for services provided by PHCS network and nonparticipating providers.

[3]Kaiser Permanente Insurance Company (KPIC) pays a maximum of $600 per day combined for all hospital care received from nonparticipating providers, excluding physician, surgeon, and surgical services.

[4]For this service a deductible does not apply.

[5]Routine adult physical exams are limited to one exam every 12 months. Preventive lab tests, X-ray, and immunizations are covered as part of the preventive exam.

[6]Well-child preventive care is exempt from deductibles and includes immunizations.

[7]Kaiser Permanente Insurance Company pays a maximum of $400 per procedure for outpatient surgery services from nonparticipating providers.

[8]All outpatient therapies are limited to 60 visits per calendar year combined for both PHCS network and nonparticipating providers.

[9]The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the nonparticipating providers level. Nonemergency ambulance coverage is limited to a maximum of $2,000 per calendar year for all services.

[10]Member is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the patient requests a brand-name drug and a generic version is available.

[11]MedImpact pharmacy copayments are subject to the satisfaction of the calendar-year deductible and out-of-pocket maximum. Drugs prescribed for family planning are subject to the calendar-year deductible. Select prescription drugs are excluded from coverage.

[12]Self-administered injectable medications are limited to a 30-day maximum supply and are not available under the mail-order service. Prescriptions for insulin are covered at the brand-name or generic copayment level.

[13]Benefits payable for treatment of infertility are limited to $1,500 per lifetime combined for services provided by PHCS network or nonparticipating providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.

[14]Certain durable medical equipment and supplies are limited to a combined maximum benefit of $2,000 per calendar year for services from PHCS network and nonparticipating providers, excluding diabetic testing supplies and equipment.

[15]Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of $2,000 per calendar year.

[16]Maximum benefit while insured applies to covered charges from nonparticipating providers only.

Important notice regarding the $40/$2,500 PPO Insurance Plan with HSA Option

This chart is a summary of the benefits for a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts (HSAs) in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, as then constituted or later amended. Enrollment in an HDHP that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Please consult with your employer about other eligibility requirements for establishing an HSA-qualified plan.

Please note: If you have other health coverage, including coverage under Medicare, in addition to the coverage under this Group Policy, you may not be eligible to establish or contribute to an HSA unless both coverages qualify as High Deductible Health Plans.

Kaiser Permanente Insurance Company (KPIC) does not provide tax advice. The California Department of Insurance does **not** in any way warrant that this plan meets the federal requirements.

Consult with your financial or tax adviser for tax advice or more information about your eligibility for an HSA.

Notes for Kaiser Permanente POS and PPO plans

Precertification of services provided by PHCS network 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 network and nonparticipating providers

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.

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. Geographic areas covered by the Health Plan

DENTAL PLANS
2012 SMALL BUSINESS

For effective dates January 1–June 1, 2012

DELTA DENTAL PREMIER PLANS

For effective dates 1/1/12–6/1/12

Service	Plan C Plan pays[2]	Plan D Plan pays[2]	Plan E Plan pays[2]	Plan E with Ortho[1] Plan pays[2]	Limitations
No deductible applies to these procedures.					
Exam	100%	100%	100%	100%	Twice in a calendar year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	100%	100%	100%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Other X-rays	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%	Twice in a calendar year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	100%	100%	100%	Only for children through age 18, twice in a calendar year
Deductibles apply to procedures under plans D, E, and E with Orthodontics.					
Calendar-year deductible	No deductible	$25	$25	$25	Per person per calendar year up to a family maximum of $75 per calendar year
Annual benefit maximum	$500	$1,000	$1,000	$1,000	Annual benefit maximum represents the total annual amount paid by the plan per person, per calendar year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	80%	80%	80%	Usual, customary, and reasonable
Denture relines	Not covered	80%	80%	80%	Twice in a calendar year (limited to two upper, two lower, or any combination)[3]
Space maintainers	100%	100%	100%	100%	Usual, customary, and reasonable
Fillings	80%	80%	80%	80%	Usual, customary, and reasonable
Stainless steel crowns	80%	80%	80%	80%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Oral surgery	Not covered	80%	80%	80%	Usual, customary, and reasonable
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	Includes replacements after five years, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	50%	For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan is not covered.)

[1]Plan E with Orthodontics requires at least 10 subscribers.
[2]Benefits payable will be based on the lesser of the usual, customary, and reasonable fees or the fees actually charged.
[3]Limitation applies only to Plan D.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

DELTA DENTAL PPO PLANS

For effective dates 1/1/12–6/1/12

	PPO D 1500		PPO E 1000		PPO E 1500		Limitations
Service	***Plan pays[1] (PPO network)***	***Plan pays (out of network)***	***Plan pays[1] (PPO network)***	***Plan pays (out of network)***	***Plan pays[1] (PPO network)***	***Plan pays (out of network)***	
No deductible applies to these procedures.							
Exam	100%	50%	100%	50%	100%	50%	Twice in a calendar year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	50%	100%	50%	100%	50%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Other X-rays	80%	50%	80%	50%	80%	50%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	50%	100%	50%	100%	50%	Twice in a calendar year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	50%	100%	50%	100%	50%	Only for children through age 18, twice in a calendar year
Calendar-year deductible	$25	$50	$25	$50	$25	$50	Per person per calendar year up to a family maximum of $75 (in network) and $150 (out-of-network)
Annual benefit maximum	$1,500	$1,500	$1,000	$1,000	$1,500	$1,500	Annual benefit maximum represents the total annual amount paid by the plan per person, per calendar year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	50%	80%	50%	80%	50%	
Denture relines	80%	50%	80%	50%	80%	50%	Twice in a calendar year
Space maintainers	100%	50%	100%	50%	100%	50%	
Fillings	80%	50%	80%	50%	80%	50%	
Stainless steel crowns	80%	50%	80%	50%	80%	50%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	80%	50%	80%	50%	80%	50%	
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	80%	50%	80%	50%	80%	50%	
Oral surgery	80%	50%	80%	50%	80%	50%	
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	50%	50%	Includes one replacement in any five-year period, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials	Not covered	Not covered	50%	50%	50%	50%	Standard removable prosthetic appliances (includes one replacement in any five-year period, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

[1]Benefits payable will be based on the maximum allowable charge.

Important information for the Delta Dental Premier and Delta Dental PPO dental insurance plans

The following services are not covered under any Kaiser Permanente Insurance Company (KPIC) group dental insurance plans:

- Any treatment or procedure not listed as covered
- Charges in excess of the maximum allowable charge
- Services for injuries or conditions covered under workers' compensation or employer's liability laws
- Cosmetic surgery, dentistry, or services to correct hereditary, congenital, or developmental malformations
- Restoration of tooth structure or chewing surfaces for damages due to wear
- Prosthodontic services or procedures started prior to a person's date of eligibility
- Prescribed drugs, premedication, or pain relievers
- Experimental procedures
- Hospital costs or extra charges for hospital treatment
- Anesthesia (except general anesthesia for oral surgery)
- Extra-oral grafts, implants, or implant removal
- Treatment related to the temporomandibular joint (TMJ)
- Plaque control programs, oral hygiene, or dietary instructions
- Orthodontic treatment, except for eligible dependent children under Plan E with Orthodontics
- Treatment plans that are more expensive than those customarily provided, or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice
- Pit and fissure sealants, except for first molars of children through age 8 and second molars for children through age 15. The molar must have no decay and no restoration, and the occlusal surface must be intact. Coverage does not include the repair or replacement of a sealant on any tooth within three years of application.
- Services provided to the covered person by any federal or state governmental agency or provided without cost to the covered person by any municipality, county, or other political subdivision, except Medi-Cal benefits
- Charges by any hospital or other surgical treatment facility, or any additional fees charged by the dentist for treatment in any such facility
- Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants
- Replacement of existing restoration for any purpose other than active tooth decay
- Intravenous sedation, occlusal guards, or complete occlusal adjustment
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program
- Hypnosis
- Charges for completion of forms
- Charges for speech therapy
- Charges for lost or stolen appliances
- Services for which no charge is normally made in the absence of insurance

Predetermination of benefits is recommended for services in excess of $300. This document is not intended as a summary plan description, nor is it designed to serve as the *Certificate of Insurance* or the *Schedule of Coverage*. It contains only a summary of benefits, exclusions, and limitations. If you have specific questions regarding benefit structure, limitations, or exclusions, consult the *Certificate of Insurance* and the *Schedule of Coverage* or contact Delta Dental's Customer Service Department at 1-888-335-8227, 8 a.m. to 5 p.m., Monday through Friday. For a list of in-network providers, contact Delta Dental's Customer Service Department. This dental insurance plan is underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, and administered by Delta Dental of California.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

DELTA DENTAL®
Delta Dental Plan of California
deltadentalins.com

DELTACARE HMO DENTAL PLANS

For effective dates 1/1/12–6/1/12

Services	DeltaCare 10A	DeltaCare 13B	Limitations
Preventive care			
Periodic and comprehensive – oral evaluation	No cost	No cost	Twice in a calendar year
Bitewing X-rays	No cost	No cost	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Prophylaxis	No cost	No cost	Twice in a calendar year
Fluoride treatments	No cost	No cost	Only for children up to age 19, twice in a calendar year
Space maintainers	$10	$50	Removable – unilateral
Periodontics			
Maintenance	No cost	$35	Twice in a calendar year
Scaling and root planing	No cost	$50	Limited to four quadrants per calendar year
Surgery – osseous (includes flap entry and closure)	$175	$300	Four or more teeth per quadrant
Restorative			
Fillings – primary or permanent amalgam	No cost	No cost	One to four surfaces
Composite crowns – resin-based	$35	$145	Composite (indirect)
Crown – porcelain	$195	$355	
Inlay – metallic	No cost	$145	One surface
Endodontics			
Therapeutic pulpotomy	No cost	$25	Excludes final restoration
Root amputation	No cost	$70	Per root
Root canal – anterior	$45	$95	Excludes final restoration
Root canal – molar	$205	$335	Excludes final restoration
Prosthodontics			
Complete denture	$100	$285	The enrollee must continue to be eligible, and the service must be provided at the contract dentist facility where the denture was originally delivered
Reline maxillary or mandibular denture – chairside	No cost	$50	Complete or partial
Reline maxillary or mandibular denture – laboratory	$35	$85	Complete or partial
Oral and maxillofacial surgery			
Extraction – erupted tooth or exposed root	No cost	$5	Elevation and/or forceps removal
Surgical removal of erupted tooth	$15	$45	
Orthodontics			
Comprehensive orthodontic – child	$1,700	$1,900	Child or adolescent to age 19
Comprehensive orthodontic – adult	$1,900	$2,100	Adults, including covered dependent adult children

Benefits listed above are only a sample of provided services and associated costs. Costs will vary. Please see the *Evidence of Coverage (EOC)* for a comprehensive list of all services and costs. DeltaCare benefits are only covered when performed by an in-network California DeltaCare HMO provider. In California, DeltaCare USA is underwritten and administered by Delta Dental of California.

Exclusions of benefits for the DeltaCare HMO dental plans

Exclusions

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*
2. Any procedure that in the professional opinion of the contract dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry
3. Services solely for cosmetic purposes, with the exception of procedure D9972 (external bleaching, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns, and fixed partial dentures (bridges) for children under 16 years of age
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, and fixed partial dentures (bridges)
6. Procedures, appliances, or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ)
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith), and personalization and characterization of complete and partial dentures
8. Implant-supported dental appliances and attachments; implant placement, maintenance, or removal; and all other services associated with a dental implant
9. Consultations for noncovered benefits
10. Dental services received from any dental facility other than the assigned contract dentist, a preauthorized dental specialist, or a contract orthodontist except for *Emergency Services* as described in the contract and/or *Evidence of Coverage*
11. All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility
12. Prescription drugs
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken, and orthodontics unless qualified for the orthodontic treatment in progress provision
14. Lost, stolen, or broken orthodontic appliances
15. Changes in orthodontic treatment necessitated by accident of any kind
16. Myofunctional and parafunctional appliances and/or therapies
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances
18. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services

For additional benefit information or a directory of Delta dentists, please call Delta Dental at **1-800-422-4234** or visit **deltadentalins.com**.

KAISER PERMANENTE®

DELTA DENTAL®
Delta Dental Plan of California
deltadentalins.com

CHIROPRACTIC AND ACUPUNCTURE PLANS
2012 SMALL BUSINESS

For effective dates January 1–June 1, 2012

CHIROPRACTIC AND ACUPUNCTURE PLAN – $15 COPAY/20 VISITS

Chiropractic services are administered by American Specialty Health Plans of California, Inc.® (ASH Plans)

Features

Office visit copayment: $15 per visit

Office visit limit: 20 combined visits per calendar year

Chiropractic appliance benefit: Chiropractic appliances are provided up to a maximum of $50 per calendar year when prescribed and provided by an ASH Plans participating chiropractor as part of your chiropractic care.

X-rays and laboratory tests: $0

Monthly premiums

Employee	$2.70
Employee + spouse	$5.40
Employee + child(ren)	$4.05
Family	$8.10

Services

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Acupuncture services are covered when a participating acupuncturist finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders, nausea, or pain. You can obtain services from any ASH Plans participating chiropractors and acupuncturists without a referral from a Kaiser Permanente Plan physician.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by ASH Plans participating chiropractors and acupuncturists.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered at no charge when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider that has contracted with ASH Plans to provide those services.

Emergency services: Covered chiropractic services are those emergency services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system. Covered acupuncture services are those emergency services provided for the sudden and unexpected treatment of a neuromusculoskeletal disorder, nausea, or pain. These conditions and injuries must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable layperson with no special knowledge of health, medicine, chiropractic care, or acupuncture could reasonably expect that a delay of immediate chiropractic care or acupuncture could result in (1) placing your health in serious jeopardy, (2) serious impairment to your bodily functions, or (3) serious dysfunction of any bodily organ or part.

Participating chiropractors and acupuncturists

ASH Plans contracts with participating chiropractors and other participating providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. ASH Plans contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, cupping, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered services from a participating provider, except for emergency chiropractic and acupuncture services and services that are not available from participating providers that are previously authorized by ASH Plans. The list of participating chiropractors and acupuncturists is available on the ASH Plans website at **ashcompanies.com** or from the ASH Plans Member Services Department at **1-800-678-9133**. The list of participating chiropractors and acupuncturists is subject to change at any time without notice.

How to obtain covered services

To obtain covered services, call a participating chiropractor or acupuncturist to schedule an initial examination. If additional services are required, your participating chiropractor or acupuncturist will prepare a treatment plan. The ASH Plans Clinical Services Manager will authorize the treatment plan if the services are medically necessary chiropractic services and acupuncture services for you. ASH Plans will disclose to you, upon request, the process that it uses to authorize a treatment plan. If you have questions or concerns, please contact ASH Plans Member Services Department.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copayments. **This benefit cannot be offered with the HSA-qualified deductible HMO plans, the PPO plan, or the PPO plan with HSA option.** Please refer to the *Chiropractic Services and Acupuncture Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, emergency chiropractic services, and emergency acupuncture services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of participating chiropractors and participating acupuncturists available to you. You can obtain covered services from any participating chiropractor or participating acupuncturist without a referral from a Plan physician. Cost sharing is due when you receive covered services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc. Evidence of Coverage* for terms you should know.

Getting assistance

If you have a question or concern regarding the services you received from a participating provider, you may call ASH Plans Member Services at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans
Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Dispute resolution

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as why you believe a decision was in error or why you are dissatisfied about services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

KAISER PERMANENTE®

American Specialty Health Plans of California

CHIROPRACTIC AND ACUPUNCTURE PLAN FOR THE KAISER PERMANENTE $40/$1,000 PPO INSURANCE PLAN – $15 COPAY/20 VISITS

Features

Office visit copayment: $15 per visit

Office visit limit: 20 visits per calendar year

Chiropractic appliance benefit: Chiropractic appliances are provided up to a maximum of $50 per calendar year when prescribed by a PHCS participating chiropractor.[1]

Monthly premiums

Employee	$4
Employee + spouse	$8
Employee + child(ren)	$6
Family	$12

Services

You can obtain chiropractic and acupuncture services from any participating provider without a referral from a physician. Except for the initial examination, your chiropractic benefits are limited to medically necessary chiropractic services for the treatment or diagnosis of neuromusculoskeletal disorders that are due to subluxation and are treatable by manual manipulation of the spine.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by a PHCS network provider.[2]

How to obtain services

You must receive chiropractic or acupuncture services from a participating provider in the PHCS network.[3] Choose from more than 2,000 providers in California and thousands of others nationwide. To find a provider near you, visit **multiplan.com/kaiser**. Depending on your plan, deductibles or copayments paid under the chiropractic and acupuncture coverage may not count toward satisfying your medical deductible and out-of-pocket maximum.

Note: This benefit cannot be offered with the $40/$2,500 PPO Plan with HSA Option.
Chiropractic and acupuncture coverage for the Kaiser Permanente $40/$1,000 PPO Insurance Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. This is only a summary of your benefits and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copayments. Benefits may vary depending on the terms of your plan. Please refer to the KPIC *Certificate of Insurance* and *Schedule of Coverage* for a detailed description of your chiropractic and acupuncture benefits, including exclusions, limitations, and emergency chiropractic services.

[1] Chiropractic appliances are limited to the following items: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, wrist braces, rib supports, rib belts, home traction units (cervical or lumbar), and ankle braces.

[2] It is possible that your chiropractor may perform physical therapy–related services not covered under your chiropractic benefits. Please refer to your KPIC *Certificate of Insurance* for complete details about which services are covered.

[3] KPIC has contracted with Private Healthcare Systems (PHCS) to give you access to providers with a commitment to keeping out-of-pocket costs low through contracted rates.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

NOTES

NOTES

businessnet.kp.org

Small Business
60076901_V2 October 2011

KAISER PERMANENTE®