2025 MMC Global Plan Rates

Carrier & Plan Name	Description	Enrollment Tiers & Rates			
		Employee	Employee + Spouse	Employee +Child(ren)	Family
Kaiser Permanente HMO40	*$40 Office Co-Pay – Annual Ded $3,000/$6,000* *Calendar out-of-pocket Max - $6,000/$12,000* *Inpatient & Outpatient Hospital - 30% after Ded* *Emergency 30% after ded ~ Ambulance $150* *Rx $10 Generic/$30 Brand*	**$591.12**	**$1,265.00**	**$1,117.22**	**$1,891.58**
Kaiser Permanente HMO25	*$25 Office Co-Pay* *Calendar out-of-pocket Max - $1,500* *Inpatient Hosp $500/admit ~Outpatient $25* *Emergency $125 ~ Ambulance $150* *Rx $15 Generic/$30 Brand*	**$817.58**	**$1,749.62**	**$1,545.22**	**$2,616.26**
Kaiser Permanente PPO	*Annual Deductible $4,500/$6,500* *Calendar Out of Pocket Max $6,500* *$40 Office Co-Pay, Hospital $1,000 Ded/30%* *ER $100, Rx $40/$15*	**$1,106.04**	**$2,366.90**	**$2,090.40**	**$3,539.30**
Minimum Employer contribution for Medical Enrollees = $300/per month per EE					
Aetna Freedom of Choice	*DMO: Preventative 100%, Basic 100%, Major 60%,* *$5 office Co-Pay, Ortho Adult & Child 50%* *PPO In-network Option: $50 Deductible* *Preventative 100%, Basic 80%, Major 50%,* *PPO Out-of-Network: $50 Deductible* *Preventative 80%/Basic 60%/Major 50%*	**$52.70**	**$97.90**	**$94.80**	**$135.30**
VSP	*In Network: $25 Deductible* *Exam & Lenses – Covered every 12 months* *Frames $200/ 24 mos.+ $50 Enhanced Feature Frame* *Contact Lenses - $130 allowance*	**$18.70**	**$29.60**	**$29.80**	**$44.60**

Reminder: Annual preventative health services provided at $0 Copay
Schedule your check up and refer to your summary of benefits for details & information

California Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30)

Employee Number

Effective date of enrollment/change* (mm/dd/yyyy)

Reason for enrollment if adding subscriber and/or dependent(s)

- ☐ Open enrollment period
- ☐ Birth of eligible dependent
- ☐ Newly eligible, new hire, rehire, or increase in hours
- ☐ Special enrollment period (as described under "Additional information" on page 2) due to triggering event on (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan Arbitration Agreement.† I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

KAISER PERMANENTE®

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City State ZIP code

The following special enrollment information applies to coverage under a small group plan: If you decline coverage for yourself or an eligible dependent when you are first eligible to enroll, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*Field required for all enrollments and changes.

Disclosure Form Part One

107720 MEDICAL MANAGEMENT CONSULTANTS, INC.
Home Region: Southern California
1/1/25 through 12/31/25

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Services	You Pay
Emergency department visits	$125 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$150 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$500 per admission

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Disclosure Form Part One

(continued)

Substance Use Disorder Treatment	You Pay
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Services, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

Disclosure Form Part One

107720 MEDICAL MANAGEMENT CONSULTANTS, INC.
Home Region: Southern California
1/1/25 through 12/31/25

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$6,000	$6,000	$12,000
Plan Deductible	$3,000	$3,000	$6,000
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$40 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$40 per visit after Plan Deductible

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	30% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible

Emergency Services	You Pay
Emergency department visits	30% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$150 per trip after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

Disclosure Form Part One

(continued)

Prescription Drug Coverage	You Pay
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$40 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$20 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$40 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Services, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

2025 Benefit Summary	PPO Plan 10233 NCR / 10234 SCR	
	Participating Provider Tier[15]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
The Accumulation Period for this Plan is **Calendar Year**		
Maximum benefit while insured	Unlimited	
	Insured pays	
Deductible per accumulation period[1][2]	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family
Out-of-Pocket Maximum per accumulation period	$6,500 Individual $13,000 Family	$13,000 Individual $26,000 Family
Hospital care	$1,000 Copayment per admission, then	$1,500 Copayment per admission, then
Room, board, and critical care units	30%	50%
Imaging, including X-rays and lab tests	30%	50%
Transplants	30%	50%
Physician, surgeon, and surgical services	30%	50%
Nursing care, anesthesia, and inpatient prescribed drugs	30%	50%
Birth Services[7]	30%	50%
Outpatient care		
Physician office visits	$40 Copayment[3]	50%[3]
Specialty care	$40 Copayment[3]	50%[3]
Telehealth visits[8]	$40 Copayment[3]	50%[3]
Preventive screening services	No charge[3]	50%[3]
Routine adult physical exam	No charge[3][4]	50%[3][4]
Well-child preventive care visits	No charge[3][5]	50%[3][5]
Family planning visits	$40 Copayment[3]	50%
Prenatal care[6]	No charge[3]	50%[3]
Outpatient Surgery	$100 Copayment, then 30% per procedure	$150 Copayment, then 50% per procedure
Lab Test and Imaging, including X-rays	30%	50%
Hearing exams	No charge[3]	Not covered
Occupational, physical, respiratory, and speech therapy visits	30%	50%
Health Education	No charge[3]	50%
Diabetic Day Care Management Classes	No charge[3]	50%
Emergency Care (Emergency Copayment waived if admitted)	$100 Copayment per visit, then 30%	
Emergency Ambulance Service	50%	50%
Medically Necessary Non-emergency Ambulance Service	50%	50%
Urgent Care	30%	50%

2025 Benefit Summary	PPO Plan 10233 NCR / 10234 SCR	
	Participating Provider Tier[15]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
	Insured pays	
Prescriptions[9]	**MedImpact Pharmacies[10][16]**	**Non-Participating Pharmacies**
Generic drugs (30-day supply)	$15 Copayment	Not covered
Brand drugs (30-day supply)	$40 Copayment	Not covered
Contraceptive drugs	No charge	Not covered
Specialty drugs[11]	30% with $250 per prescription maximum	Not covered
Mail-order generic drugs (maximum benefit of a 100-day supply)	$30 Copayment	Not covered
Mail-order brand drugs (maximum benefit of a 100-day supply)	$80 Copayment	Not covered
Mental health care		
Inpatient hospitalization	$1,000 Copayment per admission, then 30%	$1,500 Copayment per admission, then 50%
Outpatient individual therapy visits	$40 Copayment[3]	50%[3]
Outpatient group therapy visits	$20 Copayment[3]	50%[3]
Substance use disorder treatment		
Inpatient hospitalization	$1,000 Copayment per admission, then 30%	$1,500 Copayment per admission, then 50%
Outpatient individual therapy visits	$40 Copayment[3]	50%[3]
Outpatient group therapy visits	$20 Copayment[3]	50%[3]
Durable medical equipment[13]	30%	50%
Diabetic Equipment and Supplies[14]	30%	30%
Prosthetics, orthotics, and special footwear	30%	50%
Additional benefits		
Care in a skilled-nursing facility (60-day combined limit per benefit period)[17]	$1,000 Copayment per admission, then 30%	$1,500 Copayment per admission, then 50%
Home health care (100-day combined limit per accumulation period)[17]	20%[3]	20%[3]
Hospice care	30%	50%
Infertility services[12]	30%[3]	50%[3]

Note: These benefits are subject to regulatory approval.

This chart only describes a summary of the benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company Schedule of Coverage and *Certificate of Insurance*, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this Benefit Summary is not intended for use as a Summary Plan Description, nor is it designed to serve as the Schedule of Coverage or *Certificate of Insurance*.

Footnotes

(1) Deductibles contribute towards satisfying the Out-of-Pocket Maximum. This plan carries an embedded Deductible and Out-of-Pocket Maximum. Benefits become payable for each family member after their individual annual Deductible is met, 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 Deductible or Out-of-Pocket Maximum at the Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier. Likewise, Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Non-Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum on the Non-Participating Provider Tier. The Deductible, Copayments, and Coinsurance paid for most covered services contribute towards the satisfaction of the Out-of-Pocket Maximum.

(3) Exempt from Deductible.

(4) Routine adult physical exams are limited to one exam every 12 months.

(5) Well-child preventive care, including immunizations, is exempt from Deductible.

(6) Routine prenatal care office visits are covered as required under the Patient Protection Affordable Care Act (PPACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.

(7) Birth Services including delivery and inpatient care for mother and baby are covered under your inpatient services benefit.

(8) Telehealth care is provided where applicable and available via communication methods such as telephone, video, or email. Cost shares vary depending on the type of service provided and are equivalent to an in-person visit specific to that service.

(9) Member is responsible for paying the brand name Copayment plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is prescribed by the physician.

(10) MedImpact Pharmacy Copayment and Coinsurance are not subject to, nor do they contribute toward satisfaction of the Deductible. However, they do contribute toward the satisfaction of the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.

(11) Specialty drugs are limited to a 30-day maximum supply and are not available under the mail order service.

(12) Benefits payable for treatment of infertility are limited to $1,000 per accumulation period combined for services provided by Participating Providers or Non-Participating Providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness. Covered Charges for infertility services do not accumulate towards satisfaction of the Out-of-Pocket Maximum.

(13) Certain Durable Medical Equipment is limited to a maximum of $2,000 per accumulation period combined for services provided by Participating Providers and Non-Participating Providers. Certain Durable Medical Equipment is not subject to the Deductible nor contributes to the Out-of-Pocket Maximum.

(14) 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 Durable Medical Equipment annual maximum limit of $2,000 per accumulation period.

(15) Online directories of Participating Providers available to you can be found by visiting kp.org/kpic/ppo.

(16) An online directory of Pharmacies available to you can be found by visiting kp.org/pharmacylocator/ppo.

(17) The visit maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorder.

†Precertification of services provided by Participating Providers and Non-Participating Providers
Precertification is required for all hospital confinements, including preadmission testing, inpatient care at a skilled-nursing facility, or other licensed, 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 a penalty of $500 per occurrence for Covered Charges incurred in connection with these services. This penalty will not count toward the satisfaction of any Deductibles or Out-of-Pocket Maximums. For a complete understanding of the precertification requirements, please refer to your **Schedule of Coverage** and ***Certificate of Insurance.***

***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; or 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.

PPO Benefits are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP)

Aetna

Enrollment/Change Request

Aetna Life Insurance Company (underwriter/administrator of Dental PPO. Dental EPP and Indemnity Dental coverages)
Aetna Dental Inc. (underwriter of DMO* coverage)

Check One: ☐ PPO Dental ☐ DMO®

See Instructions on the back of the front page.

A. Transaction Information

EFFECTIVE DATE (MM/DD/YR) ______

1. Enrollment (Check One)

☐ New Enrollee
Hire Date __/__/__ (MM DD YR)

☐ Rehired/Reinstatement
Date __/__/__ (MM DD YR)

☐ Return to Work
Date __/__/__ (MM DD YR)

2. Change — From / To

☐ Social Security Number ___-__-____ ___-__-____
☐ Control/Suffix/Account ______ ______
☐ Stop Continuation of Dental Coverage (i.e.. COBRA)
☐ Other ______

3. Termination

☐ Terminating Employment - Reason ______
☐ Cancelling Coverage - Reason ______
☐ Continue Employee Dental Coverage (i.e., COBRA)
☐ Continue Dependent Dental Coverage (i.e.. COBRA)

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)	8. Network ID

C. Employee Information - Please Print All Information

1. Employee Social Security Number	2. Employee Name (Last, First, Middle Initial)	3. Employee Home Address
- -		Number, Street, Apt

4. Employee Status	5. Sex	6. Home Telephone Number	7. Work Telephone Number	City	State	ZIP Code
☐ Active ☐ Retired		( ) -	( ) -			

D. Individuals Covered (List individuals for whom you are electing/changing coverage.)

☐ Check this box if you are refusing coverage for your dependents.

*Additional information required. See Instruction page

(A)dd/New (C)hange (R)emove	Relation. Code	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks)	Social Security Number (If dependent has no SSN, write "None")	Birthdate MM / DD / YYYY	Dependent Address (If different than employee)	Late Entrant	Prior Insur. Plan	Other Dental Coverage	Currently Covered by Medicare	Handi-capped	Student Age 19 or Older	Primary Care Dentist ID # / Primary Care Dentist Name	Prev. Seen
						Yes	Yes*	Yes*	Yes	Yes*	Yes*		Yes
	Self		- -	/ /	Not Applicable	☐	☐	☐	☐	N/A	N/A	ID # ___ Name ___	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name ___	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name ___	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name ___	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name ___	☐
			- -	/ /		☐	☐	☐	☐	☐	☐	ID # ___ Name ___	☐

Special Remarks

E. Acknowledgments - Signatures Required

Employee's E-mail Address:

I have read and agree to the terms of the authorization on the back of this Enrollment/Change Request form. I understand that. in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event. my and my dependents' eligibility may be affected.

Employee Signature X ______ Date ______ **Employer Signature X** ______ Date ______

Dental Benefits Summary

	DMO® Member Responsibility
Annual Deductible	
Individual	**None**
Family	**None**
Preventive Services	**0%**
Basic Services	**0%**
Major Services	**40%**
Annual Benefit Maximum	**None**
Office Visit Copay	**$5**
Orthodontic Services (Adult and Child)	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	*******

***** 24 months of comprehensive orthodontic treatment plus 24 months of retention.**

Partial List of Services	DMO® Member Responsibility
Preventive	
Oral examinations (a)	**0%**
Cleanings (a) Adult/Child	**0%**
Fluoride (a)	**0%**
Sealants (permanent molars only) (a)	**0%**
Bitewing Images (a)	**0%**
Full mouth series Images (a)	**0%**
Basic	
Root canal therapy	**0%**
Anterior teeth / Bicuspid teeth Scaling	**0%**
and root planing (a)	**0%**
Gingivectomy (a)*	**0%**
Amalgam (silver) fillings	**0%**
Composite fillings (anterior teeth only)	**0%**

Dental Benefits Summary

Stainless steel crowns	**0%**
Incision and drainage of abscess*	**0%**
Uncomplicated extractions	**0%**
Surgical removal of erupted tooth*	**0%**
Surgical removal of impacted tooth (soft tissue)*	**0%**
Major	
Space Maintainers	**40%**
Inlays	**40%**
Onlays	**40%**
Crowns	**40%**
Full & partial dentures	**40%**
Pontics	**40%**
Root canal therapy, molar teeth	**40%**
Osseous surgery (a)*	**40%**
Surgical removal of impacted tooth (partial bony/ full bony)*	**40%**
General anesthesia/intravenous sedation*	**40%**
Denture repairs	**40%**
***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**	
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.	

Other Important Information

This benefits summary of the Aetna Dental DMO (Dental Maintenance Organization) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®

Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY, MA and OH and for members residing in OK (regardless of contract situs state).

Attention Massachusetts residents Before enrolling, you should be aware that our network of preferred providers in Massachusetts has providers mainly in the following counties: Barnstable, Berkshire, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester. Your out of pocket expenses will be higher if you do not see an in-network provider and, in some plans, benefits may not be available at all for out-of-network providers.

Dental Benefits Summary

	Active PPO MAX With PPOII and ExtendSM Networks	
	Participating	Non-participating
Annual Deductible*		
Individual	**$50**	**$150**
Family	**$150**	**$450**
Preventive Services	**100%**	**80%**
Basic Services	**80%**	**60%**
Major Services	**50%**	**50%**
Annual Benefit Maximum	**$1500**	**$1500**
Office Visit Copay	**N/A**	**N/A**
Orthodontic Services	**Not Covered**	**Not Covered**
Orthodontic Deductible	**Not Covered**	**Not Covered**
Orthodontic Lifetime Maximum	**Not Covered**	**Not Covered**

***The deductible applies to: Basic & Major services only**

Partial List of Services	Active PPO MAX With PPOII and ExtendSM Networks	
	Participating	Non-participating
Preventive		
Oral examinations (a)	**100%**	**80%**
Cleanings (a) Adult/Child	**100%**	**80%**
Fluoride (a)	**100%**	**80%**
Bitewing Images (a)	**100%**	**80%**
Full mouth series Images (a)	**100%**	**80%**
Basic		
Denture repairs	**80%**	**60%**
Space Maintainers	**80%**	**60%**
Root canal therapy		
Anterior teeth / Bicuspid teeth	**80%**	**60%**
Root canal therapy, molar teeth	**80%**	**60%**
Scaling and root planing (a)	**80%**	**60%**
Gingivectomy (a)*	**80%**	**60%**

Dental Benefits Summary

Amalgam (silver) fillings	**80%**	**60%**
Composite fillings (anterior teeth only)	**80%**	**60%**
Stainless steel crowns	**80%**	**60%**
Incision and drainage of abscess*	**80%**	**60%**
Uncomplicated extractions	**80%**	**60%**
Surgical removal of erupted tooth*	**80%**	**60%**
Surgical removal of impacted tooth (soft tissue)*	**80%**	**60%**
Osseous surgery (a)*	**80%**	**60%**
Surgical removal of impacted tooth (partial bony/ full bony)*	**80%**	**60%**
General anesthesia/intravenous sedation*	**80%**	**60%**
Major		
Inlays	**50%**	**50%**
Onlays	**50%**	**50%**
Crowns	**50%**	**50%**
Full & partial dentures	**50%**	**50%**
Pontics	**50%**	**50%**

***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**

(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) MAX benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) MAX plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO MAX plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

2025 - ENROLLMENT/CHANGE/TERMINATION FORM

GROUP NUMBER: 12103137/DIVISION NUMBER: 0001

vsp Vision care for life

Please Print

EMPLOYEE NAME: _____

EMPLOYER: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

_____

Effective Date: _____

Please Select One:

- ○ Enrollment (initial eligibility, qualifying event, or Open Enrollment)
- ○ Change (addition or deletion of dependents)
- ○ Termination (cancellation of coverage)

Coverage Level/Please Select Tier:

○	EMPLOYEE ONLY	$ 18.70 / MONTH
○	EMPLOYEE + SPOUSE	$29.60/ MONTH
○	EMPLOYEE + CHILD (REN)	$29.80 / MONTH
○	EMPLOYEE + FAMILY	$44.60 / MONTH

Employee Signature: _____

Date: _____

A Look at Your VSP Vision Coverage

With VSP and MEDICAL MANAGEMENT CONSULTANTS, INC., your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.
With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra

$50

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON. · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

MEDICAL MANAGEMENT CONSULTANTS, INC. and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$25 for exam and glasses Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME†	• $250 Visionworks frame allowance on any frame • $250 Enhanced Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Classification: Restricted