

**CVT KAISER HEALTH / RX PLANS – 1 Through 7
2006 / 2007**

BENEFIT	KAISER NORTH 1	KAISER NORTH 2	KAISER NORTH 3	KAISER NORTH 4	KAISER NORTH 5	KAISER NORTH 6	KAISER NORTH 7
DOCTOR VISITS	Covered, No Charge	Covered, \$10 Copay	Covered, \$10 Copay	Covered, \$20 Copay	Covered, \$25 Copay	Covered, \$15 Copay	Covered, \$25 Copay
ANNUAL PHYSICAL	Covered, No Charge	Covered, \$10 Copay	Covered, \$10 Copay	Covered, \$20 Copay	Covered, \$25 Copay	Covered, \$15 Copay	Covered, \$25 Copay
IMMUNIZATIONS	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge	Covered, No Charge Up To Age 2 After Age 2 - \$10 Copay	Covered, No Charge Up To Age 2 After Age 2 - \$10 Copay	Covered, No Charge Up To Age 2 After Age 2 - \$20 Copay	Covered, No Charge Up To Age 2 After Age 2 - \$25 Copay	Covered, \$5 Copay Up To Age 2 After Age 2 - \$15 Copay	Covered, \$15 Copay Up To Age 2 After Age 2 - \$25 Copay
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Covered, No Charge	Pap Smear-Covered, \$10 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$10 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$20 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$25 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$15 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$25 Copay Mammogram-Covered, No Charge
OUTPATIENT X-RAY & LAB	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge
PHYSICAL THERAPY	Covered, No Charge	Covered, \$10 Copay	Covered, \$10 Copay	Covered, \$20 Copay	Covered, \$25 Copay	Covered, \$15 Copay	Covered, \$25 Copay
CHIROPRACTIC	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
ACUPUNCTURE	Covered, No Charge Referral by Plan Physician	Covered, \$10 Copay Referral by Plan Physician	Covered, \$10 Copay Referral by Plan Physician	Covered, \$20 Copay Referral by Plan Physician	Covered, \$25 Copay Referral by Plan Physician	Covered, \$15 Copay Referral by Plan Physician	Covered, \$25 Copay Referral by Plan Physician
HOSPITAL INPATIENT	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, No Charge	Covered, \$250 Copay	Covered, \$250 Copay
HOSPITAL EMERGENCY ROOM	Covered, No Charge	Covered, \$35 Copay Waived if Admitted	Covered, \$35 Copay Waived if Admitted	Covered, \$35 Copay Waived if Admitted	Covered \$35 Copay Waived if Admitted	Covered \$50 Copay Waived if Admitted	Covered \$100 Copay Waived if Admitted
RADIATION THERAPY, CHEMOTHERAPY & SURGERY	Covered, No Charge	Inpatient: Covered, No Charge Outpatient: \$10 Copay	Inpatient: Covered, No Charge Outpatient: \$10 Copay	Inpatient: Covered, No Charge Outpatient: \$20 Copay	Inpatient: Covered, No Charge Outpatient: \$25 Copay	Inpatient: Covered, No Charge Outpatient: \$15 Copay	Inpatient: Covered, No Charge Outpatient: \$50 Copay
HOME HEALTH CARE	Covered, No Charge (Limits)	Covered, No Charge (Limits)	Covered, No Charge (Limits)	Covered, No Charge (limits)	Covered, No Charge (limits)	Covered, No Charge (limits)	Covered, No Charge (limits)

<i>Page 2</i>	KAISER NORTH 1		KAISER NORTH 2		KAISER NORTH 3		KAISER NORTH 4		KAISER NORTH 5		KAISER NORTH 6		KAISER NORTH 7	
HOSPICE	Covered, No Charge		Covered, No Charge		Covered, No Charge		Covered, No Charge		Covered, No Charge		Covered, No Charge		Covered, No Charge	
DURABLE MEDICAL EQUIPMENT	Covered, No Charge In accord with DME Formulary		Covered, No Charge In accord with DME Formulary		Covered, No Charge In accord with DME Formulary		Covered, No Charge In accord with DME Formulary		Covered, No Charge In accord with DME Formulary		Covered, No Charge In accord with DME Formulary		Covered, 20% coinsurance In accord with DME Formulary	
AMBULANCE-GROUND/AIR	Covered, No Charge, If Medically Necessary		Covered, No Charge, If Med. Necessary		Covered, No Charge, If Med. Necessary		Covered, No Charge, If Med. Necessary		Covered, No Charge, If Med. Necessary		Covered, \$50 Per Trip		Covered, \$100 Per Trip	
MENTAL HEALTH - INPATIENT	Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, \$250 Per Admission 45 days per calendar year (limits) No limits with AB88 Parity		Covered, \$250 Per Admission -- 30days per calendar year (limits) No limits with AB88 Parity	
MENTAL HEALTH OUTPATIENT	Covered, No Charge; 20 visits per calendar year No limits with AB88 Parity		Covered, \$10 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$10 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$20 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$25 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$15 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$25 Copay; 20 visits per calendar year No limits with AB88 Parity	
SUBSTANCE ABUSE INPATIENT	Detox – No Charge Transitional Residential Recovery Services - \$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – \$250 per admission Transitional Residential Recovery Services-\$100 per admission (limits)		Detox – \$250 per admission Transitional Residential Recovery Services-\$100 per admission (limits)	
SUBSTANCE ABUSE OUTPATIENT	Covered, No Charge for individual visits; No Charge for group visits (no limits)		Covered, \$10 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$10 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$20 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$25 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$15 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$25 Copay for individual visits; \$5 Copay for group visits (no limits)	
OUT OF POCKET MAXIMUM	Not Applicable		\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family	
LIFETIME MAX PER PERSON	No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<u>Retail</u> \$5 copay (Up to 100 day supply)	<u>Mail Order</u> \$5 copay Refills Only	<u>Retail</u> \$5 Gen \$10 Brnd (Up to 100 day supply)	<u>Mail Order</u> \$5 Gen \$10 Brnd Refills Only	<u>Retail</u> \$10 Gen \$20 Brnd (Up to 100 day supply)	<u>Mail Order</u> \$10 Gen \$20 Brnd Refills Only	<u>Retail</u> \$10 Gen \$15 Brnd (Up to 100 day supply)	<u>Mail Order</u> \$10 Gen \$15 Brnd Refills Only	<u>Retail</u> \$10 Gen \$20 Brnd (Up to 100 day supply)	<u>Mail Order</u> \$10 Gen \$20 Brnd Refills Only	<u>Retail</u> \$10 Gen \$20 Brnd (Up to 100 day supply)	<u>Mail Order</u> \$10 Gen \$20 Brnd Refills Only	<u>Retail</u> \$10 Gen \$30 Brnd (Up to 30 day supply)	<u>Mail Order</u> \$20 Gen \$60 Brnd (Up to 100 day supply)

NOTE: Plans 1 through 5 – No copay for injections or infertility. Plans 6 and 7 - \$5 copay for injections; infertility covered at 50%.

THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.