



| <i>Page 2</i>                           | <b>KAISER 1</b>  |                                   | <b>KAISER 2</b>   |   | <b>KAISER 3</b>   |  | <b>KAISER 4</b>   |  | <b>KAISER 5</b>   |  | <b>KAISER 6<br/>w/<br/>Optical Benefit</b>  |  | <b>KAISER 7</b>   |  | <b>KAISER 8<br/>Deductible Plan</b>  |  |
|---|--|-----------------------------------|---|---|---|--|---|--|---|--|---|--|---|--|--|--|
| <b>HOSPICE</b>                          | Covered, No Charge   |                                   | Covered, No Charge  |   | Covered, No Charge  |  | Covered, No Charge  |  | Covered, No Charge  |  | Covered, No Charge  |  | Covered, No Charge  |  | Covered, No Charge   |  |
| <b>DURABLE MEDICAL EQUIPMENT</b>        | Covered, No Charge<br>In accord with DME Formulary   |                                   | Covered, No Charge<br>In accord with DME Formulary  |   | Covered, No Charge<br>In accord with DME Formulary  |  | Covered, No Charge<br>In accord with DME Formulary  |  | Covered, No Charge<br>In accord with DME Formulary  |  | Covered, No Charge<br>In accord with DME Formulary  |  | Covered, 20% coinsurance<br>In accord with DME Formulary  |  | Covered, 20% Coinsurance, No Deductible,<br>In accord with DME Formulary                                       |  |
| <b>AMBULANCE-GROUND/AIR</b>             | 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, No Charge, If Med. Necessary   |  | Covered, \$50 Per Trip  |  | Covered, \$100 Per Trip   |  | Covered, \$150 Per Trip, No Deductible, If Med. Necessary  |  |
| <b>MENTAL HEALTH - INPATIENT</b>        | 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         |  | Covered, 20% Coinsurance after Deduct., 30 days per calendar year (Limits) No limits with AB88 Parity          |  |
| <b>MENTAL HEALTH OUTPATIENT</b>         | 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                         |  | Covered, No Deductible, \$20 Copay; 20 visits per calendar year No limits wi/AB88 Parity                       |  |
| <b>SUBSTANCE ABUSE INPATIENT</b>        | 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) Residential Rehab (30 days cal yr) – No Charge (Limits) |  | Detox – \$250 per admission Transitional Residential Recovery Services-\$100 per admission (Limits) |  | Detox – 20% Coinsurance after Deduct., Transitional Residential Recovery Services-\$100 per admission (Limits) |  |
| <b>SUBSTANCE ABUSE OUTPATIENT</b>       | 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)                   |  | Covered, No Deduct, \$20 Copay for individual visits; \$5 Copay for group visits (No Limits)                   |  |
| <b>OUT OF POCKET MAXIMUM</b>            | 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   |  | \$3,000 Per Person \$6,000 Per Family  |  |
| <b>LIFETIME MAX PER PERSON</b>          | No Lifetime Maximum  |                                   | No Lifetime Maximum   |   | No Lifetime Maximum   |  | No Lifetime Maximum   |  | No Lifetime Maximum   |  | No Lifetime Maximum   |  | No Lifetime Maximum   |  | No Lifetime Maximum  |  |
| <b>PRESCRIPTION DRUGS (CO-PAYMENTS)</b> | Retail \$5 copay<br>(Up to 100 day supply)   | Mail Order \$5 copay Refills Only | Retail \$5 Gen \$10 Brnd<br>(Up to 100 day supply)  | Mail Order \$5 Gen \$10 Brnd Refills Only | Retail \$10 Gen \$20 Brnd<br>(Up to 100 day supply)   | Mail Order \$10 Gen \$20 Brnd Refills Only | Retail \$10 Gen \$15 Brnd<br>(Up to 100 day supply)   | Mail Order \$10 Gen \$15 Brnd Refills Only | Retail \$10 Gen \$20 Brnd<br>(Up to 100 day supply)   | Mail Order \$10 Gen \$20 Brnd Refills Only | Retail \$10 Gen \$20 Brnd<br>(Up to 100 day supply)   | Mail Order \$10 Gen \$20 Brnd Refills Only | Retail \$10 Gen \$30 Brnd<br>(Up to 30 day supply)  | Mail Order \$20 Gen \$60 Brnd (Up to 100 day supply) | Retail \$10 Gen \$30 Brnd<br>(Up to 30 day supply)   | Mail Order \$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%. Plan 6 has \$175 allowance for lenses, frames, & contacts every 24 months. Plan 8 – No copay for allergy injections, infertility covered at 50% plus deductible. THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.**