CALIFORNIA'S VALUED TRUST
KAISER HEALTH / RX PLANS – 1 Through 8
2009 / 2010

BENEFIT	KAISER 1	KAISER 2	KAISER 3	KAISER 4	KAISER 5	KAISER 6 w/ Optical Benefit	KAISER 7	KAISER 8 Deductible Plan
DEDUCTIBLE	N / A							$1,000 Individual $2,000 Family
DOCTOR VISITS	Covered, No Charge	Covered, $10 Copay		Covered, $20 Copay	Covered, $25 Copay	Covered, $15 Copay	Covered, $25 Copay	Covered, $20 Copay, No Deductible
ANNUAL PHYSICAL	Covered, No Charge	Covered, $10 Copay		Covered, $20 Copay	Covered, $25 Copay	Covered, $15 Copay	Covered, $25 Copay	Covered, $20 Copay, No Deductible
IMMUNIZATIONS	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 - $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	Covered, No Deduct, $10 Copay, Up To Age 2 After Age 2 - $20 Copay
WELL WOMAN: PAP SMEAR/ 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	Pap Smear-Covered, $20 Copay Mammogram- Covered, $10 Copay No Deductible
OUTPATIENT X-RAY & LAB	Covered, No Charge							Covered, No Deduct, $10 Copay
VISION EXAM	Covered, No Charge No frame, lense, contact allowance	Covered, $10 Copay No frame, lense, contact allowance		Covered, $20 Copay No frame, lense, contact allowance	Covered, $25 Copay No frame, lense, contact allowance	Covered, $15 Copay $175 frame, lense, contact allowance	Covered, $25 Copay No frame, lense, contact allowance	Covered, $20 Copay No frame, lense, contact allowance
PHYSICAL THERAPY	Covered, No Charge	Covered, $10 Copay		Covered, $20 Copay	Covered, $25 Copay	Covered, $15 Copay	Covered, $25 Copay	Covered, No Deduct, $20 Copay
CHIROPRACTIC	Not Covered							
ACUPUNCTURE	Covered, No Charge 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	Covered, No Deduct, $20 Copay Referral by Plan Physician
HOSPITAL INPATIENT	Covered, No Charge					Covered, $250 Copay		Covered, 20% Coinsurance after Deductible
HOSPITAL EMERGENCY RM	Covered, No Charge	Covered $35 Copay Waived if Admitted				Covered $50 Copay Waived if Admitted	Covered $100 Copay Waived if Admitted	Covered, 20% Coinsurance after Deductible
RADIATION THERAPY, CHEMOTHERAPY	Covered, No Charge	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	Inpatient: Covered, 20% after Deductible Outpatient: Covered, No Charge
HOME HEALTH CARE	Covered, No Charge (Limits)							

Page 2	KAISER 1	KAISER 2	KAISER 3	KAISER 4	KAISER 5	KAISER 6 w/ Optical Benefit	KAISER 7	KAISER 8 Deductible Plan
HOSPICE	Covered, No Charge							
DURABLE MEDICAL EQUIPMENT	Covered, No Charge In accord with DME Formulary						Covered, 20% coinsurance In accord with DME Formulary	Covered, 20% Coinsurance, No Deductible, In accord with DME Formulary
AMBULANCE-GROUND/AIR	Covered, No Charge, If Med. Necessary					Covered, $50 Per Trip	Covered, $100 Per Trip	Covered, $150 Per Trip, No Deductible, If Med. Necessary
MENTAL HEALTH - INPATIENT	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 – 30 days 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
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, $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
SUBSTANCE ABUSE INPATIENT	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 – 20% Coinsurance after Deduct., 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, $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)
OUT OF POCKET MAXIMUM	Not Applicable	$1,500 Per Person $3,000 Per Family						$3,000 Per Person $6,000 Per Family
LIFETIME MAX PER PERSON	No Lifetime Maximum							
PRESCRIPTION DRUGS (CO-PAYMENTS)	Kaiser 1 Retail $5 copay (Up to 100 day supply) Mail Order $5 copay Refills Only	Kaiser 2 Retail $5Generic $10 Brand (Up to 100 day supply) Mail Order $5 Generic $10 Brand Refills Only	Kaiser 3 Retail $10 Generic $20 Brand (Up to 100 day supply) Mail Order $10 Generic $20 Brand Refills Only	Kaiser 4 Retail $10 Generic $15 Brand (Up to 100 day supply) Mail Order $10 Generic $15 Brand Refills Only	Kaiser 5 & 6 Retail $10 Generic $20 Brand (Up to 100 day supply) Mail Order $10 Generic $20 Brand Refills Only		Kaiser 7 & 8 Retail $10 Generic $30 Brand (Up to 30 day supply) Mail Order $20 Generic $60 Brand (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.