



BENEFIT	KAISER 1	
DEDUCTIBLE / OUT-OF-POCKET MAX	Deductible: 0 Out-of-Pocket Max: \$1,500 Per Person \$3,000 Per Family	
LIFETIME MAXIMUM PER PERSON	No Lifetime Maximum	
DOCTOR VISITS	Covered, \$10 Copay	
IMMUNIZATIONS	Covered, No Charge	
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge	
PREVENTIVE CARE FOR ADULTS	Covered, No Charge	
OUTPATIENT X-RAY & LAB	Covered, No Charge	
RADIATION THERAPY, CHEMOTHERAPY	Radiation Therapy: Covered, No Charge Chemotherapy: \$10 Copay	
DURABLE MEDICAL EQUIPMENT	Covered, No Charge In accord with DME Formulary	
AMBULANCE-GROUND/AIR	Covered, No Charge, If Med. Necessary	
PHYSICAL THERAPY	Covered, \$10 Copay	
CHIROPRACTIC	Not Covered	
ACUPUNCTURE	Covered, \$10 Copay Referral by Plan Physician	
HOSPITAL INPATIENT	Covered, No Charge	
HOSPITAL EMERGENCY ROOM	Covered \$35 Copay Waived if Admitted	
HOME HEALTH CARE	Covered, No Charge (Limits)	
HOSPICE	Covered, No Charge	
VISION EXAM	Covered, No Charge No frame, lense, contact allowance	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<u>Retail</u> \$5 Generic \$10 Brand (Up to 30 day supply)	<u>Mail Order</u> \$10 Generic \$20 Brand (100 Day Supply)

NOTES: COPAYS FOR INFERTILITY: Plan 1 - \$10 Copay;
 COPAYS FOR ALLERGY INJECTIONS: Plan 1 – No Charge
 THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.