



BENEFIT	KAISER PLAN 8 Deductible Plan	
DEDUCTIBLE / OUT-OF-POCKET MAX	Deductible: \$1,000 Individual / \$2,000 Family Out-of-Pocket Max: \$3,000 Per Person / \$6,000 Per Family	
LIFETIME MAXIMUM PER PERSON	No Lifetime Maximum	
DOCTOR VISITS	Covered, \$20 Copay, No Deductible	
IMMUNIZATIONS	Covered, No Charge	
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge	
PREVENTIVE CARE FOR ADULTS	Covered, No Charge	
OUTPATIENT X-RAY & LAB	Covered, No Deductible \$10 Copay	
RADIATION THERAPY, CHEMOTHERAPY	Radiation Therapy: Covered, 20% after Deductible Chemotherapy: Covered, No Charge	
DURABLE MEDICAL EQUIPMENT	Covered, 20% Coinsurance, No Deductible, In accord with DME Formulary	
AMBULANCE-GROUND/AIR	Covered, \$150 Per Trip, No Deductible, If Med. Necessary	
PHYSICAL THERAPY	Covered, No Deductible \$20 Copay	
CHIROPRACTIC	Not Covered	
ACUPUNCTURE	Covered, No Deductible, \$20 Copay Referral by Plan Physician	
HOSPITAL INPATIENT	Covered, 20% Coinsurance after Deductible	
HOSPITAL EMERGENCY RM	Covered, 20% Coinsurance after Deductible	
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)	Retail \$10 Generic \$30 Brand (Up to 30 day supply)	Mail Order \$20 Generic \$60 Brand (100 day supply)

NOTES: COPAYS FOR INFERTILITY: Plan 8 – 50% Copay
 COPAYS FOR ALLERGY INJECTIONS: Plan 8 – No Charge
 THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY
 PLAN DESCRIPTION FOR COMPLETE BENEFITS.