

Kaiser Permanente Medical Plans Benefit Summary (1)

Benefits shown are for Kaiser Permanente Providers ONLY.

Benefit Description	\$5 Co-Pay Plan	\$15 Co-Pay Plan	\$20 Co-Pay Plan	\$30 Co-Pay Plan	\$50 Co-Pay Plan
Annual Calendar Year Deductible	None	None	None	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Calendar Year Out-of-Pocket Maximum: (2)	\$1,500/person \$3,000/family	\$3,000/person \$6,000/family	\$3,000/person \$6,000/family	\$3,500/person \$7,000/family	\$3,500/person \$7,000/family
Amounts Listed Are Member Payments					
Office Visits	\$5	\$15	\$20	\$30	\$50
Preventive Exams	\$5	\$15	\$20	\$30	\$50
Maternity/Pre-Natal (Scheduled pre-natal visits and first postpartum visit)	No Charge	No Charge	No Charge	No Charge	\$15 (2)
X-Ray and Lab Most labs and imaging MRI/CT/PET Scan	\$10 \$50	\$10 \$50	\$10 \$50	\$10 \$50	\$10 \$50
Inpatient Hospitalization	\$0	\$200 per day	\$300 per day	\$400 per day	\$500 per day
Outpatient Surgery	\$5 per procedure	\$100 per procedure	\$150 per procedure	\$200 per procedure	\$250 per procedure
Ambulance Services	\$75	\$75	\$75	\$75	\$300
Emergency Room (not resulting in direct hospital admission)	\$100	\$100	\$100	\$100	\$150
Prescription Drugs (3):	Up to 100 Day Supply	Up to 30 Day Supply	Up to 30 Day Supply	Up to 100 Day Supply	Up to 100 Day Supply
Brand-Name Deductible	None	None	None	\$250	\$250
RX Co-Pays:					
Brand Name	\$15	\$25	\$30	\$35	\$35
Generic	\$5	\$10	\$10	\$10 (4)	\$10 (4)
Certain Durable Medical Equipment (DME)	20%	20%	20%	Not covered (5)	Not covered (5)
Vision Exam	\$5	\$15	\$20	\$30	\$50
Optical Eye Wear	\$150 allowance (7)	\$150 allowance (7)	Not covered (6)	Not covered (6)	Not covered (6)

(1) This document is a summary of benefits only. Refer to contract for a detailed explanation of plan benefits, features, exclusions and limitations. Benefits valid for plan year 6/1/09 to 5/31/10 and subject to change without notice. For a detailed listing of plan benefits and a copy of the Evidence of Coverage please visit: www.Realcare.biz/eoc

(2) The annual out of pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the Evidence of Coverage)

(3) Prescription drugs are covered in accord with a Kaiser formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the Evidence of Coverage for detailed information about prescription drug copayments.

(4) Not subject to a deductible

(5) Please refer to the Evidence of Coverage for more information; most DME is not covered.

(6) Kaiser Permanente member are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional or packaged eyewear program, for any contact lens extended purchase agreement, or to low-vision aids or devices.

(7) allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.

Kaiser is not available in all areas. Please check Kaiser's Medical rating regions to determine whether you qualify.

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Benefit Description	HSA Compatible Plans			
	0/\$1,500 Plan (HSA Compatible)	0/\$2,200 Plan (HSA Compatible) <i>(To be discontinued 6/1/10)</i>	0/\$2,700 Plan (HSA Compatible)	\$30/\$2,700 Plan (HSA Compatible)
Annual Calendar Year Deductible (2) or (3)	\$1,500/person \$3,000/family (2)	\$2,200/person \$4,400/family (2)	\$2,700/person \$5,450/family (3)	\$2,700/person \$5,450/family (3)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Calendar Year Out-of-Pocket Maximum:	\$1,500/person \$3,000/family	\$2,200/person \$4,400/family	\$2,700/person \$5,450/family	\$5,250/person \$10,500/family
Amounts Listed Are Member Payments				
Office Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$30 after deductible
Preventive Exams	\$0 (5)	\$0 (5)	\$0 (5)	\$30 (5)
Maternity/Pre-Natal <small>(Scheduled pre-natal visits and first postpartum visit)</small>	\$0 (5)	\$0 (5)	\$0 (5)	\$10 (5)
X-Ray and Lab Most labs and imaging MRI/CT/PET Scan	\$0 after deductible \$0 after deductible	\$0 after deductible \$0 after deductible	\$0 after deductible \$0 after deductible	\$10 after deductible \$50 after deductible
Inpatient Hospitalization	\$0 after deductible	\$0 after deductible	\$0 after deductible	30% after deductible <small>(per admission)</small>
Outpatient Surgery	\$0 after deductible	\$0 after deductible	\$0 after deductible	30% after deductible
Ambulance Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 after deductible
Emergency Room <small>(not resulting in direct hospital admission)</small>	\$0 after deductible	\$0 after deductible	\$0 after deductible	30% after deductible
Prescription Drugs (6):	Up to 100 Day Supply			
<i>Rx Deductible</i>	<i>Same as medical deductible</i>	<i>Same as medical deductible</i>	<i>Same as medical deductible</i>	<i>Same as medical deductible</i>
RX Co-Pays:				
<i>Brand Name</i>	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$30 after deductible
<i>Generic</i>				\$10 after deductible
Certain Durable Medical Equipment (DME) (7)	Not covered	Not covered	Not covered	Not covered
Vision Exam	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$30 after deductible
Optical Eye Wear (8)	Not covered	Not covered	Not covered	Not covered

Deductible HMO Plans <small>(Not HSA Compatible)</small>	
\$30/\$1,500 Plan	\$30/\$1,000 Plan
\$1,500/person \$3,000/family (3)	\$1,000/person \$2,000/family (3)
Unlimited	Unlimited
\$3,500/person \$7,000/family	\$3,500/person \$7,000/family

Amounts Listed Are Member Payments	
\$30 (5)	\$30 (5)
\$30 (5)	\$30 (5)
No Charge (5)	No Charge (5)
\$10 after deductible \$50 after deductible	\$10 after deductible \$50 after deductible
\$500/day after deductible	\$500/day after deductible
\$250 after deductible	\$250 after deductible
\$75 after deductible	\$75 after deductible
\$100 after deductible	\$100 after deductible
Up to 100 Day Supply	
\$250	\$250
\$35 after Rx deductible	\$35 after Rx deductible
\$10 (5)	\$10 (5)
Not covered	Not covered
\$30 (5)	\$30 (5)
Not covered	Not covered

The \$0/\$2200 plan will be eliminated 6/1/10. In addition, Kaiser will be making significant changes to all HSA compatible health plans effective 6/1/10. Please visit www.RealCare.biz/Realtors for more information or call (800) 939-8088, Ext. 202

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- (2) The entire family deductible must be met before copayments apply for individual family members.
- (3) Each family member becomes eligible for copayments after meeting his or her individual deductible.
- (4) The annual out of pocket maximum is the limited to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the Evidence of Coverage).
- (5) Not subject to a deductible
- (6) Prescription drugs are covered in accord with a Kaiser formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the Evidence of Coverage for detailed information about prescription drug copayments.
- (7) Please refer to the Evidence of Coverage for more information; most DME is not covered.
- (8) Kaiser Permanente member are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts will not apply to any sale, promotional or packaged eyewear program, for any contact lense extended purchase agreement, or to low-vision aids or devices.

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