

**Aaron Services Inc.**  
**Health Insurance Comparison**  
**In-Network Benefits Plan Comparison**

| <b>Benefit Description</b>   | <b>Option 1<br/>Kaiser HMO D<br/>IN-NETWORK</b>  | <b>Option 2<br/>Kaiser KP Gold 1500/0/20/S3<br/>IN-NETWORK</b>                      | <b>Option 3<br/>Kaiser KP Silver 2500/25/40/S3<br/>IN-NETWORK</b>                                    |
|--|--|---|--|
| <b>Annual Deductible (single/family)</b>                                   | \$500/\$1,500  | \$1,500/\$3,000   | \$2,500/\$5,000  |
| <b>Coinsurance</b>   | Plan pays 80% after deductible   | Plan pays 100% after deductible   | Plan pays 75% after deductible   |
| <b>Out-of-Pocket Maximum (single/family) (includes deductible)</b>         | \$2,000/\$6,000  | \$5,000/\$13,700  | \$6,850/\$13,700   |
| <b>Maximum Benefit</b>   | Unlimited  | Unlimited   | Unlimited  |
| <b>Office Visits: Preventive Care</b>                                      |  |   |  |
| Primary Care Physician Office Visit  | \$0 Copay; deductible waived   | \$0 Copay; deductible waived  | \$0 Copay; deductible waived   |
| Specialist Physician Office Visit  | \$0 Copay; deductible waived   | \$0 Copay; deductible waived  | \$0 Copay; deductible waived   |
| Well Child Care  | \$0 Copay; deductible waived   | \$0 Copay; deductible waived  | \$0 Copay; deductible waived   |
| <b>Office Visits: Illness or Injury</b>                                    |  |   |  |
| Primary Care Physician (PCP) office visit                                  | \$25 Copay   | \$40 Copay  | \$40 Copay   |
| Specialty Care Physician office visit                                      | \$35 Copay   | \$60 Copay  | \$60 Copay   |
| <b>Emergency Room Services</b>   |  |   |  |
| Life-threatening illness, serious accidental injury                        | \$100 Copay per visit; waived if admitted  | \$350 Copay per visit   | Plan pays 75% after deductible   |
| Urgent Care  | \$50 Copay per visit   | \$40 Copay per visit  | \$80 Copay per visit   |
| <b>Hospital Services - Inpatient</b>                                       |  |   |  |
| Facility/ Hospital Charges   | Plan pays 80% after deductible   | Plan pays 100% after deductible   | Plan pays 75% after deductible   |
| Physician Fees for Surgical and Medical Services                           | Plan pays 80% after deductible   | Included with Facility Fee  | Plan pays 75% after deductible   |
| <b>Outpatient Services</b>   |  |   |  |
| Surgery facility/Hospital charges  | Plan pays 80% after deductible   | \$500 Copay per visit   | Plan pays 75% after deductible   |
| Diagnostic Lab services  | Plan pays 80% after deductible   | \$0 Copay in KP Facility/\$20 Copay in hospital setting                             | Plan pays 75% after deductible in KP Facility/<br>Plan pays 65% after deductible in hospital setting |
| Diagnostic X-Ray   | Plan pays 80% after deductible   | \$0 Copay in KP Facility/\$50 Copay in hospital setting                             | Plan pays 75% after deductible in KP Facility/<br>Plan pays 65% after deductible in hospital setting |
| Major Diagnostics, Lab and X-Ray (CT, PET, MRI, MRA, and nuclear medicine) | Plan pays 80% after deductible   | \$80 Copay in KP Facility/\$160 Copay in hospital setting                           | Plan pays 75% after deductible in KP Facility/<br>Plan pays 65% after deductible in hospital setting |
| Physician Fees for Surgical and Medical Services                           | Plan pays 80% after deductible   | Included with Facility Fee  | Plan pays 75% after deductible   |
| <b>Prescription Drugs</b>  |  |   |  |
| Prescription Drug Deductible   | <b>*Refills must be obtained through a Kaiser Pharmacy or through home delivery.</b><br>\$150 Individual/\$450 Family<br>(Not applicable to Generic Drugs) | <b>*Refills must be obtained through a Kaiser Pharmacy or through home delivery</b> | <b>*Refills must be obtained through a Kaiser Pharmacy or through home delivery.</b>                 |
| Preventive Generic Drugs   | \$10 Copay at KP Pharmacy/\$16 Copay at Network Pharmacy   | None  | None   |
| Preferred Generic Drugs  | \$10 Copay at KP Pharmacy/\$16 Copay at Network Pharmacy   | \$5 Copay at KP Pharmacy/\$15 Copay at Network Pharmacy                             | \$5 Copay at KP Pharmacy/\$15 Copay at Network Pharmacy  |
| Preferred Brand Drugs  | \$20 Copay after deductible at KP Pharmacy/\$26 Copay after deductible at Network Pharmacy   | \$15 Copay at KP Pharmacy/\$25 Copay at Network Pharmacy                            | \$20 Copay at KP Pharmacy/\$30 Copay at Network Pharmacy   |
| Non-Preferred Drugs  | N/A  | \$30 Copay at KP Pharmacy/\$40 Copay at Network Pharmacy                            | \$40 Copay at KP Pharmacy/\$50 Copay at Network Pharmacy   |
| Specialty Drugs  | N/A  | \$50 Copay at KP Pharmacy/\$60 Copay at Network Pharmacy                            | \$60 Copay at KP Pharmacy/\$70 Copay at Network Pharmacy   |
|  |  | Member pays 20%   | Member pays 25%  |