# # 4 - RCUH KAISER MEDICAL PLAN SUMMARY

## PLAN YEAR JULY 1, 2010 – JUNE 30, 2011

| BENEFITS | KAISER PERMANENTE GROUP PLAN A & B (my.kp.org/hi/rcuh) | |
|---|---|---|
| For more details: | (808) 432-5955, 1-800-966-5955 neighbor islands | |
| Coverage | Oahu, Maui, Hawaii, and Kauai | |
| Annual Deductible | None | |
| Out of Pocket Maximum (Annual) | $2,000 Individual/$6,000 Family | |
| Lifetime Maximum | Unlimited | |
| Physicians Services:<br>Office Visits & Surgery – Outpatient<br>Hospital Visits & Surgery – Inpatient | <br>You pay $15<br>No charge | |
| Inpatient Hospital Services: Room & Board, Ancillary (includes Lab & X-Ray) | Plan B: Room and Board, Ancillary: No Charge<br>Plan A: Room and Board, Ancillary: No Charge | |
| Outpatient Diagnostic, Lab, X-Ray & Radiotherapy | Plan B: No Charge<br>Plan A: 50% of applicable charges | |
| Annual Preventative Care Exams and Immunizations | No Charge | |
| Well Baby Care | No Charge | |
| Emergency Services | Plan B: You pay $50 per visit at a facility within the Hawaii service area (plus other applicable plan charges)<br>Plan A: You pay $75 per visit at a facility within the Hawaii service area (plus other applicable plan charges)<br>You pay 20% of reasonable and customary charges (plus other applicable plan charges) outside of Hawaii service area | |
| Urgent Care | You pay $15 at any Kaiser Permanente facility | |
| Ambulance | 20% of reasonable and customary (R&C) charges, plus any charges above R&C charges | |
| Mental Health Outpatient | You pay $15 | |
| Mental Health Inpatient | No Charge | |
| Chemical Dependency Services | Outpatient: You pay $15; Inpatient: No Charge | |
| **DRUG PLAN** | **Drug Plan 15** | |
| Prescription Drugs | $15 for each prescription not exceeding a 30 consecutive day supply or one dose of injectable drug | |
| Mail Order Maintenance Med (up to 90 day supply) | Members may purchase mail order refills for most maintenance drugs for a 90 consecutive day supply upon payment of two drug co-pays. Limited to address inside the state of Hawaii. | |
| **VISION PLAN** | **Optical Plan 1** | |
| Vision Visit | You pay $15 (eye exam for eyeglasses) | |
| <br>Standard Lenses<br>Frame<br>Contact Lenses<br>Professional Fees (for contact lenses fitting) | 1 pair of eyeglasses OR contacts every 24 months<br>No charge for lenses each 12 months<br>Member pays amount over $40; avail once every 24 mo<br>Member pays amount over $45; avail once every 24 mo<br>Member pays amount over $70 | |
| **Premium Cost (Per Month)** | **PLAN B** | **PLAN A** |
| <br>Single Plan<br>2-Party Plan<br>3+ Family Plan | **Employee +** (Employer) = *Total*<br>$**129.47** + ($194.20) = *$323.67*<br>$**258.94** + ($388.40) = *$647.34*<br>$**447.96** + ($671.94) = *$1,119.90* | **Employee +** (Employer) = *Total*<br>$**121.05** + ($181.57) = *$302.62*<br>$**242.10** + ($363.15) = *$605.25*<br>$**418.83** + ($628.25) = *$1,047.08* |

REVISED 4/22/2010