4 - RCUH KAISER MEDICAL PLAN SUMMARY

PLAN YEAR JULY 1, 2011 – JUNE 30, 2012

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: Office Visits & Surgery – Outpatient Hospital Visits & Surgery – Inpatient	 You pay $15 No charge
Inpatient Hospital Services: Room & Board, Ancillary (includes Lab & X-Ray)	Plan B: Room and Board, Ancillary: No Charge Plan A: Room and Board, Ancillary: No Charge
Outpatient Diagnostic, Lab, X-Ray & Radiotherapy	Plan B: No Charge 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) Plan A: You pay $75 per visit at a facility within the Hawaii service area (plus other applicable plan charges) 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)
 Standard Lenses & Frame **OR** Contact Lenses Professional Fees (for contact lenses fitting)	1 pair of eyeglasses OR contacts every 24 months No charge for lenses each 12 months Member pays amount over $40; avail once every 24 mo **OR** Member pays amount over $45; avail once every 24 mo Member pays amount over $70
Premium Cost (Per Month)	**PLAN B** / **PLAN A**
	Employee + (Employer) = *Total* / **Employee +** (Employer) = *Total*
Single Plan	$**129.47** **+** ($194.20) = *$323.67* / $**121.05** **+** ($181.57) = *$302.62*
2-Party Plan	$**258.94** **+** ($388.40) = *$647.34* / $**242.10** **+** ($363.15) = *$605.25*
3+ Family Plan	$**447.96** **+** ($671.94) = *$1,119.90* / $**418.83** **+** ($628.25) = *$1,047.08*

*Grandfathered Coverage: RCUH believes coverage under the Kaiser Service Agreement is a "grandfathered health plan" under the Patient Protection and Affordability Care Act. Questions regarding grandfathered health plans may be directed to the Kaiser Customer Service Center at (808) 432-5955.