RCUH KAISER MEDICAL PLAN SUMMARY
PLAN YEAR JULY 1, 2015 – JUNE 30, 2016

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 A: Room and Board, Ancillary: No Charge Plan B: Room and Board, Ancillary: No Charge
Outpatient Diagnostic, Lab, X-Ray & Radiotherapy	Plan A: 50% of applicable charges Plan B: No Charge
Annual Preventative Care Exams and Immunizations	No Charge
Well Baby Care	No Charge
Emergency Services	Plan A: You pay $75 per visit at a facility within the Hawaii service area (plus other applicable plan charges) Plan B: You pay $50 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 per visit
Mental Health Inpatient	No Charge
Chemical Dependency Services	Outpatient: You pay $15; Inpatient: No Charge
Chiropractic Services	$15 per visit / up to 20 visits
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 150**
Vision Visit	You pay $15 (eye exam for eyeglasses)
Glasses **OR** Contact Lens	$150 allowance may be used toward the following eyewear and services Glasses frames/lens/lens treatment **OR** Contact lens/contact lens exam and fitting services

Premium Cost (Per Month)	PLAN A	PLAN B
	Employee + (Employer) = *Total*	**Employee +** (Employer) = *Total*
Single Plan	$**168.82** + ($253.37) = *$422.29*	$**193.41** + ($290.11) = *$483.52*
2-Party Plan	$**337.83** + ($506.75) = *$844.58*	$**386.82** + ($580.22) = *$967.04*
3+ Family Plan	$**584.45** + ($876.67) = *$1,461.12*	$**669.19** + ($1,003.79) = *$1,672.98*

NOTE: This is a high level summary & does not contain complete information. Please refer to plan certificate for complete information on benefits & provisions.

*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.