

## 2008 Benefit Summary

### Kaiser Permanente Added Choice with 80% / 20% Out-of-Network Plan

**This is only a summary.** It does not fully describe your benefit coverage. For complete details on your benefit coverage, including exclusions, limitations, and plan terms, please refer to your employer's applicable Fact Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and riders (collectively known as "Service Agreement"), and the Kaiser Permanente Insurance Company (KPIC) Group Policy and *Certificate of Insurance*. The Service Agreement and KPIC Group Policy are the legal binding documents between Health Plan, KPIC, and your employer. In the event of ambiguity, or a conflict between this summary and the Service Agreement and KPIC Group Policy, the Service Agreement and KPIC Group Policy shall control.

Benefit	Kaiser Permanente* Member pays	Out-of-network† Member pays
<b>Calendar year deductible</b> (must be paid before benefits will become payable)	None	\$100 per member/\$300 per family (unit of 3 or more members)
<b>Maximum benefit while insured</b>	None	\$1,000,000
<b>Out-of-pocket maximum</b>	Not applicable	\$1,000 per member/\$3,000 per family (unit of 3 or more members) per calendar year
<b>Supplemental charges maximum for "basic health services"</b>	\$2,000 per member/\$6,000 per family (unit of 3 or more members) per calendar year	Not applicable
<b>Utilization management/Precertification</b>	All care and services must be provided, prescribed, or directed by a Kaiser Permanente physician, medically necessary, and received from Kaiser Permanente facilities within the Hawaii service area. Note: All references to "physician" refer to a Kaiser Permanente physician.	<b>Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.</b> Precertification is required three days prior to receiving select services listed in the out-of-network <i>Certificate of Insurance</i> . Please consult your <i>Certificate of Insurance</i> for the current listing.

Benefit	Kaiser Permanente* Member pays	Contracted provider Member pays‡	Non-contracted provider Member pays‡
<b>Preventive services</b>			
Well-child office visits (birth through age 5)	\$15 per visit	20% of MAC, deductible waived	20% of MAC, deductible waived
Well-child office visits (age 6 through 18)	\$15 per visit	20% of MAC	20% of MAC
Immunizations (birth through age 18)	No charge	Covered at 100% of MAC, deductible waived	Covered at 100% of MAC, deductible waived
Immunizations (age 19 and older)	\$10 per dose	20% of MAC	20% of MAC
Routine adult physicals	\$15 per visit	20% of MAC	20% of MAC
<b>Outpatient services</b>			
Office visits (physicians and other health professionals)	\$15 per visit	20% of MAC	20% of MAC
Routine obstetrical care	No charge upon confirmation of pregnancy	20% of MAC	20% of MAC
Abortions <sup>(1)</sup>	\$15 per visit	20% of MAC	20% of MAC
Outpatient surgery and procedures	\$15 per visit	20% of MAC	20% of MAC
Lab, imaging, and testing	10% of applicable charges	20% of MAC for X-rays and laboratory exams	20% of MAC for X-rays and laboratory exams
Administered drugs	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit copay for the visit.	20% of MAC	20% of MAC
FDA-approved contraceptive drugs and devices (to prevent unwanted pregnancies)	50% of applicable charges	20% of MAC, limited to oral, injectable, and implantable contraceptives, and devices	20% of MAC limited to oral, injectable, and implantable contraceptives, and devices

‡Benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge, (2) the negotiated rate, or (3) the actual billed charges. The member is responsible for charges that exceed the MAC when receiving services from non-participating providers.

Benefit	Kaiser Permanente* Member pays	Contracted provider Member pays <sup>‡</sup>	Non-contracted provider Member pays <sup>‡</sup>
<b>Inpatient services</b>			
Hospital room and board	\$50 per day	20% of MAC	20% of MAC
Physicians' medical and surgical services	No charge	20% of MAC	20% of MAC
Anesthesia services	No charge	20% of MAC	20% of MAC
Lab, imaging, and testing	10% of applicable charges	20% of MAC for X-rays and laboratory exams	20% of MAC for X-rays and laboratory exams
Administered drugs	No charge for most drugs administered during a covered hospital stay	20% of MAC	20% of MAC
<b>Skilled nursing care</b>	No charge up to 60 days per benefit period	20% of MAC limited to a combined benefit maximum of 120 days per calendar year	
<b>Serious mental illness</b>			
Outpatient	\$15 per visit	20% of MAC	20% of MAC
Inpatient	No charge	20% of MAC	20% of MAC
<b>Mental health services<sup>(2)</sup></b>			
Outpatient	20% of applicable charges up to 24 visits per calendar year	20% of MAC up to a combined benefit maximum of 24 visits per calendar year	
Inpatient	20% of applicable charges up to 30 days per calendar year	20% of MAC up to a combined benefit maximum of 30 days per calendar year	
<b>Substance abuse services</b>			
Outpatient	\$15 per visit	20% of MAC	20% of MAC
Inpatient	No charge	20% of MAC	20% of MAC
Residential	20% of applicable charges up to 60 days per calendar year	20% of MAC up to a combined benefit maximum of 60 days per calendar year	
<b>Emergency services (for initial treatment only)</b>			
Emergency services	Emergency medical services are covered by Kaiser Foundation Health Plan, Inc. (KFHP). Nonemergency medical services received in an emergency care setting that are not covered by KFHP may be eligible for coverage by Kaiser Permanente Insurance Company (KPIC). Emergency Department surcharge fees are not covered by KPIC.		
Within the Hawaii service area	\$50 copayment, plus other applicable plan charges		
Outside the Hawaii service area	20% of applicable charges, plus other applicable plan charges		
<b>Ambulance services</b>			
Ambulance services	20% of applicable charges, plus other applicable plan charges	20% of MAC	20% of MAC
<b>Additional services</b>			
Optical 1 (one pair of eyeglasses OR contacts every 24 months; eyeglass lens change after 12 months)	No charge for lenses; frames (amounts over \$40) OR contacts (amounts over \$45); professional fees (amounts over \$70); and lens options <sup>(3)</sup>	\$50 total allowance for lenses, frames, and contacts for out-of-network providers	Not covered
Prescription drugs <sup>(4)</sup> – drug 10	\$10 per prescription	20% of charge, but not less than \$10 per prescription for out-of-network participating pharmacies	Not covered
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply <sup>(5)</sup>	Not covered	Not covered
Internal/external prosthesis, durable medical equipment/diabetes equipment	20% of applicable charges	20% of MAC	20% of MAC
<b>Alternative medicine services<sup>(6)</sup></b>			<b>Member pays<sup>‡</sup></b>
Chiropractic services (20 visits per calendar year)			\$15 per visit
<b>Dental services<sup>(7)</sup></b>			<b>Member pays<sup>‡</sup></b>
Annual exam (once per calendar year)			100% of eligible fees
Bitewing X-rays (twice per calendar year)			100% of eligible fees
Cleaning (twice per calendar year)			100% of eligible fees
Restorative			70% of eligible fees
Prosthodontics and crowns			50% of eligible fees

<sup>‡</sup>Benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge, (2) the negotiated rate, or (3) the actual billed charges. The member is responsible for charges that exceed the MAC when receiving services from non-participating providers.

(1) Elective or medically indicated. Elective abortions limited to two per lifetime.

- (2) Not including serious mental illness.
- (3) Eye examinations for contact lenses are excluded, but the member will receive a \$70 professional fee credit for required fitting services (to apply towards the contact lenses examination) if contact lenses are purchased at a Kaiser Permanente facility.
- (4) Up to a 30-consecutive-day supply or an amount determined by the Health Plan formulary. Excludes contraceptive drugs and devices.
- (5) Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the Hawaii Service Area.
- (6) Services by American Specialty Health, Inc., only.
- (7) Services by Hawaii Dental Service (HDS) (1801) network only. Maximum amount payable by HDS for covered dental benefits in a calendar year is \$1,200 per eligible patient.