



2009 Short Benefit Summary

Kaiser Permanente Group \$14 Plan with Dental

Benefit	Member pays
Deductible	None
Lifetime maximum	None
Annual supplemental charges maximum per calendar year	\$2,000 per member/\$6,000 per family unit (3 or more members)
Preventive services	
Well-baby office visits	No charge
Immunizations	No charge
Office visits for physical exams	No charge
Outpatient services	
Office visits (doctors' and other health professionals')	\$14 per visit
Lab, imaging, and testing	10% of applicable charges
Outpatient surgery and procedures	\$14 per visit
Routine obstetrical care ⁽¹⁾	No charge upon confirmation of pregnancy
Abortions ⁽²⁾	\$14 per visit
Administered drugs	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit copayment for the visit.
FDA-approved contraceptive drugs and devices to prevent unwanted pregnancy	50% of applicable charges
Inpatient services	
Hospital room and board	No charge
Doctors' medical and surgical services	No charge
Anesthesia services	No charge
Lab, imaging, and testing	10% of applicable charges
Administered drugs	No charge for most drugs that require skilled administration by medical personnel
Skilled nursing care	
Skilled nursing care (up to 60 days per benefit period)	No charge
Mental health services	
Outpatient (up to 24 visits per calendar year)	20% of applicable charges
Inpatient (up to 30 days per calendar year)	20% of applicable charges
Chemical dependency services	
Outpatient	\$14 per visit
Inpatient	No charge
Residential (up to 60 days per calendar year)	20% of applicable charges

This is only a summary. It does not fully describe your benefit coverage. For more details on your benefit coverage, exclusions, limitations, and plan terms, or for information, please refer to your employer, to *Our Physicians and Locations* directory for practitioner and provider availability, and to your *Member Handbook*.

Benefit	Member pays
Emergency services, worldwide	
For initial treatment only	\$50 per visit, plus other applicable plan charges
Ambulance services	
Ambulance services	20% of applicable charges
Optical services	
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) ⁽³⁾
Prescription Drugs	
Prescription drugs ⁽⁴⁾ – drug 10	\$10 per prescription
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply ⁽⁵⁾
Durable Medical Equipment	
Internal/external prosthesis, durable medical equipment	20% of applicable charges
Dependent eligibility	
Dependent coverage up to age 19	Unmarried dependent children are eligible up to the child's 19th birthday
Student coverage up to age 25	Unmarried dependent children who are full-time students and have the same legal address as the Subscriber are eligible up to the child's 25th birthday

All care and services must be coordinated by a Kaiser Permanente physician

Dental services through HDS⁽⁶⁾	Plan pays
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

(1) Routine scheduled prenatal visits, uncomplicated delivery, and routine postpartum visit.

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

(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. 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 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.

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