



Hawaii Medical Service Association (HMSA) HMO

Policy Number: 72769-1-8 Package: 002

Eligibility

Employee: A person employed for at least 20 hours a week for four (4) consecutive weeks, where employee benefits (including wages or salary) and taxes (i.e. FICA, Unemployment Insurance, etc.) are paid for the employee by the employer.

Initial Enrollment Period: The period of time when new employees can enroll for the first of the month following their eligibility date but no later than thirty (30) days following the completion of four (4) consecutive weeks of twenty (20) hours per week.

Eligible dependents include your legally married spouse, domestic partner and child(ren) up to age 19, or up to age 25 if full-time students at an accredited institution (12 or more credit hours). An HMSA Student Certification form must be submitted prior to the beginning of coverage and at any time thereafter upon request by HMSA. Child(ren) must be dependent upon the employee for financial support, unless there is a court order specifying that the employee carry health insurance and the employee can claim the dependent for federal income tax purposes. Child(ren) are defined as: natural child(ren), stepchild(ren), adopted child(ren), and child(ren) that the employee or the employee's spouse have been appointed legal guardianship for by a court of law. Mentally or physically challenged child(ren) over the limiting age are covered as long as they are unmarried, dependent on the employee for support, and they do not have self-sustaining employment. The member must furnish written evidence of such incapacity/dependency and any time thereafter upon request by the Association. The child's coverage shall terminate when the member's coverage terminates or when the child is no longer incapacitated and dependent.

Primary Care Physician

When you enroll in the HMSA HMO, you will need to select a primary care physician in internal medicine, general practice, family practice or pediatrics for yourself and any of your family members enrolled in the plan. The HMO requires you to see your primary care physician before a referral to a specialist will be given. HMSA HMO services are available only when they are provided or authorized by your primary care physician in your participating medical group. However, if you see doctors or use hospitals that are not members of the HMO, you will not be covered. The HMO requires a copayment at the time of service (e.g., \$15 for an office visit), and the claim for the rest of the cost will be sent to the HMO by the provider.

2007 Premium Rates

Below is the monthly premium for HMSA coverage:

Full-Time Employee (32+ Hours/week)

| | Employee | Employer | Total |
|---------------|-----------------|----------|----------|
| Employee Only | \$4.00 | \$266.12 | \$270.12 |
| Employee+ One | \$85.00 | \$455.24 | \$540.24 |
| Family | \$166.00 | \$644.36 | \$810.36 |

Part-Time Employee (20 – 31 Hours/week)

| | Employee | Employer | Total |
|---------------|-----------------|----------|----------|
| Employee Only | \$137.06 | \$133.06 | \$270.12 |
| Employee+ One | \$312.62 | \$227.62 | \$540.24 |
| Family | \$488.18 | \$322.18 | \$810.36 |

Vendor Contact Information

| Healthcare | Prescriptions |
|---|--|
| HMSA 800-948-6372 P.O. Box 860 Honolulu, HI 96808-0860 | Pharmacy 800-790-4672 www.hmsa.com |

Summary of Benefits and Copayments for 2007

This comparison is intended to provide a condensed explanation of plan benefits. Please refer to the plan brochure and certificate, which may be obtained from your employer, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the certificate, the certificate will take precedence.

| Benefit | Your Charge |
|---|---|
| Annual Deductible | None |
| Hospital Deductible Per Confinement | None |
| Annual Copayment Maximum | \$2,000 per person \$6,000 maximum per family |
| Lifetime Maximum | Unlimited |
| Student Coverage | Through age 25 |
| Benefit | Plan Pays |
| Physician Services | |
| Office Visits | All but \$15 per visit |
| Hospital Visits | All but \$15 per visit |
| Hospital Services | |
| Room & Care – semiprivate room rate; unlimited number of days | 80% |
| Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray | 80% |
| Emergency Room Facility | Statewide: All but \$50 per visit Worldwide: 80% |
| Ambulatory Surgical Center | All but \$15 per visit |
| Inpatient Surgical Services | |
| Surgery | 100% |
| Anesthesiologist | 100% |
| Outpatient Surgical Services | |
| Assistant Surgeon | \$15 |
| Anesthesiologist | \$15 |

| Benefit | Plan Pays | |
|--|---|--|
| Outpatient Laboratory & X-Ray Services | | |
| Laboratory and Pathology X-Ray Films and Diagnostic Services Radiotherapy for Malignancies and Non-Malignancies | 100% 90% for X-ray; 100% for Diagnostic Services All but \$15 per visit | |
| Mental Health Services (1) | | |
| <u>Inpatient (2)</u> Hospital & Facility Services; 30 days maximum per calendar year Psychiatrist & Psychologist Services; 30 visits maximum per calendar year <u>Outpatient (2)</u> Psychiatrist & Psychologist Services | 80% based on semiprivate room rate 80% All but \$15 for each individual or each group session 24 sessions maximum per calendar year | |
| (1) The member must first receive approval from the Benefit Manager. (2) The following mental illness conditions are not subject to mental health plan maximums: bipolar mood disorder types I and II; delusional disorder, dissociative disorder, major depressive disorder, obsessive-compulsive disorder; schizophrenia and schizoaffective disorder. | | |
| Contraceptive Supplies * | | |
| IUD Implants Injectable (a separate copayment may be charged for administration of the injection) | All but \$60 member copay per device All but \$200 member copay All but \$5/month or \$15/quarter member copay per injection | |
| Contraceptive Supplies (cont.)* | Participating Pharmacy | Non-Participating Pharmacy |
| Preferred Oral Contraceptives (3) Diaphragm Other Methods (i.e. ring and patch) (4) | All but \$5 member copay for covered preferred contraceptives All but \$10 member copay per device 100% of remaining eligible charge after \$20 member copay and differential | 80% after \$20 copay for covered preferred contraceptives 80% after \$12 member copay per device Not a benefit |
| *Benefits not subject to annual deductible. Copayments will not count towards the annual copayment maximum and benefits paid will not be subject towards the lifetime maximum. (3) Preferred oral contraceptives include: Alesse Contraceptives (Wyeth-Ayerst), Desogen and Mircette contraceptives (Organon Pharmaceuticals), Nor-Q-D contraceptives (Watson Labs), and Tri-Levlen and Yasmin contraceptives (Berlex Laboratories). (4) Member owes any difference between the average Eligible Charge of the Other Brand Name and the average Eligible Charge for Generic and Preferred drugs covered by HMSA. | | |

| Disease Management | |
|--|--|
| Asthma, Chronic Obstructive Pulmonary Disease or Diabetes | Pharmacist's medication review and education, phone calls from program nurses, information mailed to your home |
| Cardiac Disease (CAD and CHF) | Pharmacist's medication review and education, phone call from program nurse, information mailed to your home, certain members may qualify for home monitoring equipment. |
| Benefit | Plan Pays |
| Health Assessment | Services are available under the "Physical Exams" benefit and must be provided or arranged by your personal care physician (PCP). |
| Other Services | |
| Ambulance | 80% |
| Air Ambulance | 80% |
| Allergy Testing | All but \$15 per visit for outpatient |
| Blood & Blood Products | 80% |
| Chemotherapy | 80% for inpatient; All but \$15 per visit for outpatient; All but \$15 per office visit |
| Dialysis and Supplies | 80% for inpatient; All but \$15 per visit for outpatient |
| Hospice Services | 100% |
| Medical Equipment, Appliances and Supplies | 50% |
| Newborn Circumcision | Regular Plan Benefits |
| Organ Donor Services | Regular Plan Benefits |
| Organ & Tissue Transplant (5) | 80% for inpatient; 100% for outpatient |
| Outpatient Injections | All but \$15 per office visit |
| Physical/Occupational/Speech Therapy | All but \$15 per office visit |
| Vasectomy | 80% for inpatient; All but \$15 per visit for outpatient; All but \$15 per office visit Regular Plan Benefits |
| (5) This benefit level is limited to the following transplants: bone marrow, heart, heart and lung, liver, lung and simultaneous kidney/pancreas. You must receive services from a provider that is under contract with us for the specific type of transplant you will receive for those benefits to apply. Refer to your Guide to Benefits for information on other transplants. | |
| Benefits for Children | |
| Well Child Care Office Visits | 100% |
| Well Child Care Immunization | 100% |
| Well Child Care Lab Tests | 100% |

| Benefit | Plan Pays | |
|--|--|---|
| Benefits for Women | | |
| Pap Smears | 100% | |
| Mammography | 100% | |
| Well Woman Exam | 100% | |
| Total Maternity Care | Regular Plan Benefits | |
| He Hapai Pono (Prenatal care management program) | 100% | |
| Positively Pregnant (Pregnancy workshop) | 100% | |
| Benefits for Men | | |
| Prostate Specific Antigen | 100% | |
| Physical Exams | | |
| Exams | 100% | |
| Prescription Drugs | Participating Pharmacy | Nonparticipating Pharmacy |
| Generic | All but \$5 member copay | 80% after \$5 member copay |
| Preferred Brand Name | All but \$20 member copay | 80% after \$20 member copay |
| Other Brand Name (6) | 100% of remaining eligible charge after \$20 member copay and differential | 80% of remaining eligible charge after \$20 member copay and differential |
| Insulin | | |
| Preferred Brand Name | All but \$5 member copay | 80% after \$5 member copay |
| Other Brand Name | All but \$20 member copay | 80% after \$20 member copay |
| Diabetic Supplies | | |
| Preferred Brand Name | 100% | 100% |
| Other Brand Name | All but \$20 member copay | All but \$20 member copay |
| Additional Prescription Benefits | | |
| Other Oral Contraceptives (6) | 100% of remaining eligible charge after \$20 member copay and differential | 80% of remaining eligible charge after \$20 member copay and differential |
| Smoking Cessation Devices (limitations apply) | Regular Plan Benefits | Regular Plan Benefits |
| <small>(6) Member owes a copayment, plus any difference between the average Eligible Charge of the Other Brand Name and the average Eligible Charge for Generic and Preferred drugs covered by HMSA.</small> | | |

| Mail Service Prescription Program (From an HMSA contracted provider – 90 day supply) | | |
|--|---|-----------------------------------|
| Generic | All but \$10 member copay | Not a benefit |
| Preferred Brand Name | All but \$45 member copay | Not a benefit |
| Insulin | | |
| Preferred Brand Name | All but \$10 member copay | Not a benefit |
| Diabetic Supplies | | |
| Preferred Brand Name | 100% | Not a benefit |
| Notes: | | |
| <ul style="list-style-type: none"> When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy. Each drug dispensed is limited to a 30-day supply. A 30-day supply is defined as a supply lasting the member for a period consisting of 30 consecutive days. | | |
| Benefit | Plan Pays | |
| Vision Care | Participating Provider | Non-Participating Provider |
| Eye examination (One per calendar year) | All but \$15 per visit | |
| Lenses (One of the following per calendar year): | | |
| Single | 100% after \$10 member copay | Up to \$16 |
| Multifocal | 100% after \$10 member copay | Up to \$25 |
| Contact Lenses | Plan pays up to \$130 after \$25 member copay | Up to \$50 |
| Polycarbonate Lenses (for children through age 18) | 100% | Up to \$18 |
| Contact Lens Fitting (One contact lens fitting per calendar year) | Up to \$45 | Up to \$20 |
| Frames (One frame every other calendar year) (7) | 100% after \$15 member copay | Up to \$12 |
| (7) Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between HMSA's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of the lenses. | | |
| Chiropractic Benefits | | |
| Office Visits | \$10 per visit | |
| Up to 12 visits per calendar year | | |
| X-rays | 50% of eligible charges up to a maximum of \$50 per calendar year | |
| Note: To be eligible for payment, chiropractic services must be necessary for the diagnosis or treatment of an injury or illness of the back and performed by a properly licensed or certified chiropractor. | | |

Note: All plan payments that are shown as a percent, relate to a percentage of eligible charges.

[This information is deemed to be accurate. In the event that this information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.]