

**SCHEDULE E**

**Farm Credit Foundations  
Hawaii Medical Service Association "HMSA"  
HMO Option  
(Group No. 72769-1-8 Package: 002)**



## 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.

### 2008 Premium Rates

Below is the monthly premium for HMSA coverage:

#### **Full-Time Employee (32+ Hours/week)**

	<b>Employee</b>	Employer	Total
Employee Only	<b>30.00</b>	245.76	275.76
Employee+ One	<b>113.00</b>	438.52	551.52
Family	<b>195.00</b>	632.28	827.28

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

	<b>Employee</b>	Employer	Total
Employee Only	<b>152.88</b>	122.88	275.76
Employee+ One	<b>332.26</b>	219.26	551.52
Family	<b>511.14</b>	316.14	827.28

## 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 2008

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
<b>Physician Services</b>	
Office Visits	All but \$15 per visit
Hospital Visits	All but \$15 per visit
<b>Hospital Services</b>	
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
<b>Inpatient Surgical Services</b>	
Surgery	100%
Anesthesiologist	100%
<b>Outpatient Surgical Services</b>	
Assistant Surgeon	\$15
Anesthesiologist	\$15

Benefit	Plan Pays	
<b>Outpatient Laboratory &amp; X-Ray Services</b>		
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	
<b>Mental Health Services (1)</b>		
<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.		
<b>Contraceptive Supplies *</b>		
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	
<b>Contraceptive Supplies (cont.)*</b>	<b>Participating Pharmacy</b>	<b>Non-Participating Pharmacy</b>
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.		

<b>Disease Management</b>	
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.
<b>Benefit</b>	<b>Plan Pays</b>
<b>Health Assessment</b>	Services are available under the "Physical Exams" benefit and must be provided or arranged by your personal care physician (PCP).
<b>Other Services</b>	
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	80% for inpatient; All but \$15 per visit for outpatient; All but \$15 per office visit
Vasectomy	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.	
<b>Benefits for Children</b>	
Well Child Care Office Visits	100%
Well Child Care Immunization	100%
Well Child Care Lab Tests	100%

Benefit	Plan Pays	
<b>Benefits for Women</b>		
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%	
<b>Benefits for Men</b>		
Prostate Specific Antigen	100%	
<b>Physical Exams</b>		
Exams	100%	
<b>Prescription Drugs</b>	<b>Participating Pharmacy</b>	<b>Nonparticipating Pharmacy</b>
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
<b>Additional Prescription Benefits</b>		
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
(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.		

<b>Mail Service Prescription Program (From an HMSA contracted provider – 90 day supply)</b>		
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
<b>Notes:</b>		
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>		
<b>Benefit</b>	<b>Plan Pays</b>	
<b>Vision Care</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
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.		
<b>Chiropractic Benefits</b>		
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	
<b>Note:</b> 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.]