Hawaii Residency Programs Inc.

BENEFIT PLAN COMPARISON

This comparison is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the plan Guide to Benefits or 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 Guide to Benefits or certificate, the latter will take precedence.

Choices for a Healthier Hawaii

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Important Information

All copayments shown are based on eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. All services received from a nonparticipating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

For Health Plan Hawaii, services from a non-network provider are not covered with the exception of emergency care and/or referrals from your in-network personal care physician.

If you were covered by HMSA under a different group coverage immediately prior to this coverage, any maximums you accrued under the previous coverage carry forward and count against the same types of maximum amounts under this coverage. Any copayment amounts you paid toward meeting your copayment maximum will also carry over.

If you become a member under another HMSA coverage, then you will be subject to the carryover provisions of the new coverage, and not this coverage.

Note: Asterisk * = Indicates annual deductible applies.

Plan Provisions

	PREFERRED PROVIDER PLAN (357)		HEALTH PLAN HAWAII PLUS (YI)
	Participating Providers	Nonparticipating Providers	
Lifetime Maximum	$1,000,000 per person		Unlimited
Annual Copayment Maximum	$2,500 per person; Maximum: $7,500 per family		$1,500 per person; Maximum: $4,500 per family
Annual Deductible	$100 per person; Maximum: $300 per family		None

Medical Services

	PREFERRED PROVIDER PLAN (357) YOUR COPAYMENT		HEALTH PLAN HAWAII PLUS (YI) YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	
PHYSICIAN SERVICES			
Office Visits	10%	30%*	$14
Hospital Visits	10%	30%*	$14 (hospital outpatient) None (hospital inpatient)
HOSPITAL AND FACILITY SERVICES			
Hospital Room and Board; semiprivate room rate; unlimited number of days	10%	30%*	None
Hospital Ancillary	10%	30%*	None
Intensive Care Unit; Coronary Care Unit	10%	30%*	None
Emergency Room	10%	10%	$25 (in-state) $25 (BlueCard provider) 20% (worldwide)
SURGICAL SERVICES			
Surgical Procedures	10% (cutting) 20% (non-cutting)	30%*	None (outpatient surgical center) $14 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Anesthesia	10%	30%*	$14 (outpatient professional charges) None (inpatient professional charges)
LABORATORY AND RADIOLOGY			
Diagnostic Testing	20% (outpatient) 10% (inpatient)	30%*	None
Laboratory and Pathology	20% (outpatient) 10% (inpatient)	30%*	None
X-Ray and Other Radiology	20% (outpatient) 10% (inpatient)	30%*	10% (office visit) 10% (hospital outpatient) None (hospital inpatient)
Radiation Therapy for Malignancies and Non-malignancies	20% (outpatient) 10% (inpatient)	30%*	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
MENTAL HEALTH SERVICES[1]			
Hospital / Facility Services – Inpatient	10% 30 days maximum per calendar year	30%*	None 30 days maximum per calendar year
Physician Services – Inpatient	10% 30 sessions maximum per calendar year	30%*	20% 30 sessions maximum per calendar year
Physician Services – Outpatient	10% 24 sessions maximum per calendar year	30%*	$14 24 sessions maximum per calendar year

[1] The following mental illness conditions are not subject to mental health benefit maximums: bipolar types I and II, delusional disorder, dissociative disorder, major depressive disorder, obsessive-compulsive disorder, schizophrenia and schizo-affective disorder.

Medical Services

	PREFERRED PROVIDER PLAN (357)		HEALTH PLAN HAWAII PLUS (YI)
	YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	
OTHER MEDICAL SERVICES			
Allergy Testing	20%*	30%*	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
Ambulance (air)	20%*	30%*	20%
Ambulance (ground)	20%*	30%*	20%
Blood and Blood Products	20%*	30%*	20%[2]
Chemotherapy	20%*	30%*	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
Dialysis and Supplies	20%*	30%*	$14 (hospital outpatient) None (hospital inpatient)
Hospice	None	Not covered	None
Injections	20%*	30%*	$14 (office visit) None (hospital outpatient) None (hospital inpatient)
Inter-island Transportation	Not covered	Not covered	None[2]
Medical Equipment, Appliances, and Supplies	20%*	30%*	50%
Organ Donor Services	20%*	30%*	$14 (office visit) None (hospital outpatient) None (hospital inpatient)
Organ and Tissue Transplant[3]	None	Not covered	$14 (office visit) None (hospital outpatient) None (hospital inpatient)
Physical and Occupational Therapy	20% (outpatient) * 10% (inpatient)	30%*	$14 (office visit) $14 (hospital outpatient) None (hospital inpatient)
Speech Therapy	20% (outpatient) * 10% (inpatient)	30%*	$14 (outpatient) None (inpatient)
Vision Exam	Refer to Vision plan for examination benefits	Refer to Vision plan for examination benefits	$14[4] (One exam per calendar year)

[2] Copayments will not count towards the annual copayment maximum.

[3] This benefit includes transplants such as: bone marrow, heart, heart and lung, liver, lung, pancreas, simultaneous kidney/pancreas and small bowel and multivisceral. You must receive services from a provider that is under contract with us for the specific type of transplant you will receive for these benefits to apply. Refer to your Guide to Benefits for information on other transplants.

[4] If you belong to a health center that has an ophthalmologist or optometrist, you must receive your vision exam from these providers. If you don't go to your health center vision provider for your vision exam, the vision exam will not be a covered benefit and you will be responsible for payment. If your health center does not have an ophthalmologist or optometrist, you may receive your vision exam from any provider listed under the HMO Vision Network. Your plan does not provide benefits for vision exams by non-network vision providers. Contact our Customer Service department for a copy of our HMO Vision Network directory.

Special Benefits

	PREFERRED PROVIDER PLAN (357)		HEALTH PLAN HAWAII PLUS (YI)
	YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	
BENEFITS FOR CHILDREN			
Newborn Circumcision	10%	30%*	Regular Plan Benefits
Well Child Care Immunizations	None	None	None
Well Child Care Laboratory	20%	30%	None
Well Child Care Physician Office Visits	10%	30%	None
BENEFITS FOR MEN			
Prostate Specific Antigen Test	20%	30%*	Regular Plan Benefits
Vasectomy	10%	30%*	Regular Plan Benefits
BENEFITS FOR WOMEN			
Contraceptives[5]			
Implants	50%	50%	$200
IUD	50%	50%	$60
Injectables	50%	50%	$5 times the number of months the drug is effective[6]
Mammography (screening)	20%	30%	None
Pap Smears (routine)	20%	30%*	Regular Plan Benefits
Total Maternity Care	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits
Well Woman Exam	10%	30%*	None

[5] Copayments will not count towards the annual copayment maximum and benefits paid will not be applied towards the lifetime maximum.

[6] A separate copayment may be charged for administration of the injection.

Special Benefits

	PREFERRED PROVIDER PLAN (357)		HEALTH PLAN HAWAII PLUS (YI)
	YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	
PHYSICAL EXAMS	Not covered	Not covered	None
HEALTH ASSESSMENT (HEALTHPASS)	As a Preferred Provider Plan member, you and your covered dependents age 14 and older are entitled to HealthPass, a free annual health assessment from a contracted HealthPass provider that evaluates your health and lifestyle. HealthPass can also include referrals for medical screenings and physical examinations to detect early signs of disease, when appropriate, at no charge to you. The program provides professional counseling to help you design a personal health action program that fosters healthy behavior.		Services are available under the 'Physical Exams' benefit and must be provided or arranged by your personal care physician (PCP).
DISEASE MANAGEMENT AND PREVENTIVE SERVICES PROGRAMS	**As an HMSA member, you are entitled to the following programs from a participating provider.**		
HE HAPAI PONO (Prenatal Care Management Program)	A program that offers guidance to assist you in getting the appropriate care throughout your pregnancy. You will receive written information specific to your needs and links to other resources in the community.		
POSITIVELY PREGNANT (Pregnancy Workshop)	Open to all pregnant women or women thinking about starting a family. You will be given information on appropriate prenatal care, taught how to look for signs and symptoms of pre-term (early) labor and what to do if it occurs. You will also learn that treatment and medication used to stop pre-term labor work best when started early.		
HMSA'S CARE CONNECTION			
For Asthma, Chronic Obstructive Pulmonary Disease or Diabetes	Pharmacist's medication review and education, phone calls from program nurses, information mailed to your home		
For Cardiac Disease (CAD and CHF)	Pharmacist's medication review and education, phone calls from program nurses, information mailed to your home. Certain members may qualify for home monitoring equipment		
BEHAVIORAL HEALTH (Mental Health & Substance Abuse)	Screenings for depression and substance abuse, educational materials, referrals to participating providers and treatment centers, and phone calls from program clinicians if needed.		
READY, SET, QUIT!	Personalized stop-smoking program including free phone counseling for 18 months, education on therapies and strategies from a care specialist, free classes from participating providers		

For DIABETIC SUPPLIES, INSULIN and ADDITIONAL CONTRACEPTIVES please refer to your drug section.

Prescription Drugs

	DRUG 351		DRUG 352	
	YOUR COPAYMENT		YOUR COPAYMENT	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
GENERIC (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$5	$5 plus 20% of remaining eligible charge	$5	$5 plus 20% of remaining eligible charge
PREFERRED BRAND NAME (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$20	$20 plus 20% of remaining eligible charge	$20	$20 plus 20% of remaining eligible charge
OTHER BRAND NAME (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$20 plus $35 Other Brand Name cost share	$20 plus $35 Other Brand Name cost share and 20% of remaining eligible charge	$20 plus $35 Other Brand Name cost share	$20 plus $35 Other Brand Name cost share and 20% of remaining eligible charge
[7]See Additional Benefits section for Contraceptive Diaphragms.				
INSULIN				
Preferred Brand Name	$5	$5 plus 20% of remaining eligible charge	$5	$5 plus 20% of remaining eligible charge
Other Brand Name	$20	$20 plus 20% of remaining eligible charge	$20	$20 plus 20% of remaining eligible charge
DIABETIC SUPPLIES				
Preferred Brand Name	None	None	None	None
Other Brand Name	$20	$20	$20	$20
ADDITIONAL BENEFITS				
Contraceptive Diaphragms (per device)	$10	$12	$5	$5
Smoking Cessation Devices Limited to: 1) Nicotine transdermal patches; 2) Zyban and its generic equivalent	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits	Regular Plan Benefits
Spacers for Inhaled Drugs[8]	Special member rates	Special member rates	Special member rates	Special member rates
[8]HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs at special member rates.				
MAIL SERVICE PRESCRIPTION PROGRAM (From an HMSA contracted provider -- 90 day supply)				
GENERIC	$10	Not covered	$10	Not covered
PREFERRED BRAND NAME	$35	Not covered	$35	Not covered
INSULIN				
Preferred Brand Name	$10	Not covered	$10	Not covered
DIABETIC SUPPLIES				
Preferred Brand Name	None	Not covered	None	Not covered

NOTES:

- 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.

Vision Care Services

	VISION AI		VISION CK	
	YOUR COPAYMENT		**YOUR COPAYMENT**	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
EYE EXAMINATION One per calendar year	$10 annual deductible	All charges less $40 plan payment	Refer to Medical Plan for Examination Benefits	Not covered
LENSES (One of the following) One pair per calendar year:				
Single	$10 annual deductible	All charges less $16 plan payment	$10 member copayment	All charges less $16 plan payment
Multifocal	$10 annual deductible	All charges less $25 plan payment	$10 member copayment	All charges less $25 plan payment
Contact Lenses	$25 annual deductible plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment	$25 member copayment plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment
ADDITIONAL BENEFITS				
Polycarbonate Lenses (For children through age 18); One pair per calendar year	None	All charges less $18 plan payment	None	All charges less $18 plan payment
Contact Lens Fitting; One fitting per calendar year	All charges less $45 plan payment	All charges less $20 plan payment	All charges less $45 plan payment	All charges less $20 plan payment
FRAMES One frame every other calendar year	$15 annual deductible	All charges less $12 plan payment	$15 member copayment	All charges less $12 plan payment

NOTES:

- 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 lenses and contact lenses.
- If the member receives benefits for contact lenses, the member is not eligible for frames in the same year.
- Exclusions: Sunglasses, prescription inserts for diving masks and any protective eyewear, nonprescription industrial safety goggles, nonstandard items for lenses, including tinting, blending, oversized lenses, invisible bifocals or trifocals, and repair and replacement of frame parts and accessories.
- Contact lenses following cataract surgery are not a benefit.

Dental Care Services

	PARTICIPATING PROVIDER PROGRAM (L48)	DENTAL NETWORK PROGRAM (L51)
PROVISIONS	**Refer to dental certificate for age and benefit limitations.**	
Annual Maximum Benefits	$1,000	None
Choice of Dentists	HMSA Participating Provider Network (Par) or any licensed Dentist (Non-Par)	HMSA Dental Network Providers Hawaii Family Dental Centers (statewide)
PREVENTIVE CARE	**YOUR COPAYMENT**	**YOUR COPAYMENT**
Exams	None Two per calendar year	None Two per calendar year
Cleaning	None Two per calendar year	None Two per calendar year
Topical Fluoride	None Two per calendar year; through age 18	None Two per calendar year; through age 18
X-rays	None One set of bitewings per calendar year and one full mouth x-ray every 3 years	None One set of bitewings per calendar year and one full mouth x-ray every 3 years
ROUTINE CARE		
Fillings	30%	$10 per tooth for amalgam; $15 per tooth for composite resin restorations (anterior teeth and single, stand alone, facial surface of bicuspids only)
Sealants on permanent molars	30%	None
	Through age 16; one per lifetime	Through age 16; one per lifetime
Space Maintainers	30%	$25 per procedure
	Through age 13	Through age 13
Endodontics	30%	$15 per tooth for pulpotomy; $50 per tooth for root canal therapy
Periodontics	30%	$75 for gingivectomy or gingivoplasty for 4 or more contiguous teeth; $10 for 1 to 3 contiguous teeth
MAJOR CARE		
Waiting Periods – New Members	12 Months for Bridges & Dentures	12 Months for Bridges & Dentures
Crowns, Bridges	30%	$100 High noble metal
Dentures		
Partial upper or lower denture	30%	$150 per denture
Complete upper or lower denture	30%	$175 per denture
Orthodontics	Not a benefit	Special member rates