

Feature	HMSA PPO	
	In-Network	Out-of-Network
Provider	Hawaii Medical Service Association 1-808-948-6111 <a href="http://www.hmsa.com">www.hmsa.com</a>	
<b>Cost Sharing</b>		
Annual Deductible	\$0 Individual; \$0 Family	\$100 Individual; \$300 Family
Out-of-pocket maximum	\$2,500 Individual; \$7,500 Family	\$2,500 Individual; \$7,500 Family
Lifetime coverage limit	Limit does not apply	
<b>Policies/Requirements</b>		
Need to file claims	No	Yes
Domestic partner benefits	Yes	Yes
<b>Access</b>		
Ability to self-refer to OB/GYN	Yes	Yes
Ability to self-refer to specialists	Yes	Yes
Out-of-area dependent coverage	Yes	Yes
Out-of-area participant coverage	Yes	Yes
<b>Spending Account</b>		
You only	Not applicable	Not applicable
You and spouse	Not applicable	Not applicable
You and child	Not applicable	Not applicable
You and family	Not applicable	Not applicable
Eligible expenses for reimbursement	Not applicable	Not applicable
<b>Outpatient Services</b>		
Primary doctor office visit	\$12 copay	70% covered
Specialist doctor office visit	\$12 copay	70% covered
<b>Preventive Care</b>		
Annual physical exam	In Network - 100% covered; annual health assessment covered only through the HealthPass program; check with Plan for details	Not covered
Well-woman exam (includes pap)	100% covered	70% covered
Mammogram	100% covered	70% covered; deductible does not apply
Pediatric exams	100% covered; through age 5	70% covered; through age 5; deductible does not apply
Immunizations (child)	100% covered; through age 5	100% covered; through age 5; deductible does not apply
Colonoscopy	90% covered	70% covered
Cancer screenings	Check with Plan for details	Check with Plan for details
Cardiovascular screenings	Check with Plan for details	Check with Plan for details
Allergy tests and treatments	90% covered	70% covered
<b>Outpatient Care</b>		
Outpatient surgery	90% covered	70% covered
Outpatient laboratory services	100% covered	70% covered
Outpatient physical therapy	90% covered; must be medically necessary; check with Plan for details about benefit maximums	70% covered; must be medically necessary; check with Plan for details about benefit maximums

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<b>Outpatient X-ray</b>	90% covered	70% covered
<b>Outpatient occupational therapy</b>	90% covered; must be medically necessary; check with Plan for details about benefit maximums	70% covered; must be medically necessary; check with Plan for details about benefit maximums
<b>Outpatient speech therapy</b>	90% covered; must be medically necessary; limited to short-term only; check with Plan for details about benefit maximums	70% covered; must be medically necessary; limited to short-term only; check with Plan for details about benefit maximums
<b>Outpatient cardiac rehabilitation</b>	Not covered	Not covered
<b>Family Planning / Maternity Care</b>		
<b>Office visit: pre/postnatal</b>	\$12 copay; initial visit only	70% covered
<b>In-hospital delivery services</b>	100% covered	70% covered
<b>Newborn nursery services</b>	90% covered	70% covered
<b>Fertility services</b>	90% covered; limited to one IVF procedure per lifetime; preauthorization required; diagnosis and treatment of infertility not covered	70% covered; limited to one IVF procedure per lifetime; preauthorization required; diagnosis and treatment of infertility not covered
<b>In vitro fertilization</b>	90% covered; limited to one procedure per lifetime; eligibility criteria and limitations apply; check with Plan for details	70% covered; limited to one procedure per lifetime; eligibility criteria and limitations apply; check with Plan for details
<b>Artificial insemination</b>	Not covered	Not covered
<b>Female tubal ligation</b>	90% covered	70% covered
<b>Male vasectomy</b>	90% covered	70% covered
<b>Hearing</b>		
<b>Hearing evaluations</b>	90% covered	70% covered
<b>Hearing aids</b>	90% covered; limited to one hearing aid per ear every five years; digital aids limited to no more than the amount Plan would pay for analog aids	70% covered; limited to one hearing aid per ear every five years; digital aids limited to no more than the amount Plan would pay for analog aids
<b>Vision</b>		
<b>Routine vision exams</b>	Not covered	Not covered
<b>Regular lenses and frames</b>	Not covered	Not covered
<b>Contact lenses</b>	Not covered	Not covered
<b>Dental</b>		
<b>Dental implants</b>	Not covered	Not covered
<b>Accidental injury to teeth</b>	90% covered; check with Plan about details for limitations to oral surgery	70% covered; check with Plan about details for limitations to oral surgery
<b>Surgical removal of tumors, cysts and impacted teeth</b>	90% covered; removal of impacted teeth not covered	70% covered; removal of impacted teeth not covered
<b>Inpatient Services</b>		
<b>Hospital copay</b>	90% covered	70% covered
<b>Hospital semi-private room</b>	90% covered	70% covered
<b>Inpatient lab and X-ray</b>	90% covered	70% covered
<b>Inpatient surgery</b>	90% covered	70% covered
<b>Inpatient physician and surgeon services</b>	\$12 copay	70% covered

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<b>Emergency Care</b>		
Emergency room (not followed by admission)	\$50 copay	\$50 copay
Urgent care clinic visit	\$12 copay	70% covered
Ambulance services	90% covered	70% covered
<b>Prescription Drug Coverage</b>		
Annual prescription deductible	Not applicable	
Prescription drug website	Same as medical plan	
Prescription drug member services	Same as medical plan	
Prescription drug vendor	Same as medical plan	
Annual Rx out-of-pocket maximum	Not applicable	
<b>Retail</b>		
Retail generic	\$5 copay; 30 day supply; participating pharmacies only	80% covered; after \$5 copay; 30 day supply
Retail formulary brand	\$20 copay; 30 day supply; participating pharmacies only	80% covered; after \$20 copay; 30 day supply
Retail nonformulary brand	\$20 copay; plus \$35 cost-sharing charge for non-formulary drug; participating pharmacies only; 30 day supply	80% covered; after \$20 copay and \$35 cost-sharing charge for non-formulary drug
<b>Mail Order</b>		
Mail order generic	\$10 copay; 90 day supply	Not covered
Mail order formulary brand	\$45 copay; 90 day supply	Not covered
Mail order nonformulary brand	Not covered	Not covered
<b>Other</b>		
Oral contraceptives	Retail and mail order available; applicable prescription drug formulary and copays apply; check with Plan for details	Retail available only; applicable prescription drug formulary and copays apply; check with Plan for details
Fertility drugs	Check with Plan for details	Check with Plan for details
Injectables	Check with Plan for details	Check with Plan for details
<b>Mental Health</b>		
Mental Health: Combined with substance abuse	No	No
Mental Health: Outpatient coverage	\$12 copay; limited to 24 visits per calendar year	70% covered; limited to 24 visits per calendar year
Mental Health: Inpatient coverage	90% covered; facility; \$12 copay for physician; limited to 30 days per calendar year	70% covered; limited to 30 days per calendar year
<b>Substance Abuse</b>		
Detox: Outpatient coverage	\$12 copay	70% covered
Detox: Inpatient coverage	90% covered; facility; \$12 copay for physician	70% covered
Rehab: Outpatient coverage	\$12 copay	70% covered
Rehab: Inpatient coverage	90% covered; facility; \$12 copay for physician	70% covered

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	<b>Alternative Care</b>	
<b>Chiropractic</b>	Not covered	Not covered
<b>Acupuncture</b>	Not covered	Not covered
	<b>Care Management Programs</b>	
<b>Heart disease care management</b>	Yes	
<b>Hypertension care management</b>	No	
<b>Diabetes care management</b>	Yes	
<b>Asthma care management</b>	Yes	
<b>Prenatal care management</b>	Yes	
<b>Cancer care management</b>	No	
<b>Smoking cessation program</b>	Yes	
<b>Weight control program</b>	Yes	
	<b>Other</b>	
<b>Noncustodial home health care</b>	100% covered; limited to 150 visits per calendar year	70% covered; limited to 150 visits per calendar year
<b>Hospice care</b>	100% covered	Not covered
<b>Prescribed care in noncustodial skilled nursing facility</b>	90% covered; limited to 120 days per calendar year	70% covered; limited to 120 days per calendar year
<b>Durable medical equipment</b>	90% covered	70% covered
<b>Prosthetic devices</b>	90% covered	70% covered