FamilyHealth HAWAII

HIpreferred℠ Plan

Summary of Benefits Health Insurance Plan (90/10)

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained from your employer, for complete information on benefits. In the case of discrepancy between this summary and the language contained within the Guide to Benefits, the latter will take precedence.

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Dependent Age	Up to Age 26
Calendar Year (CY) Deductible*	$100 Per Person / Maximum $300 Per Family
Out of Pocket Maximum	$2,500 Per Person / Maximum $7,500 Per Family

Copayment Is (Percentage copayments are based on Eligible Medical Expenses)

Physician Services		
Summary of Benefits	**Participating**	**Non-Participating based on Eligible Medical Expense**
Physician Visits: Office, Hospital, Skilled Nursing Facility, and Home	$12 Copay per visit	30%
Consultations	$12 Copay per visit	30%
Emergency Services		
Emergency Room / Physician	10%	10%
Outpatient Emergency Room	10%	30%
Urgent Care Center Visit	$15 Copay per visit	30%
Preventive Care Services		
Physical Exams – Adult, Well Child / Adolescent, and Well Woman	$10 Copay	30%
Well Child Care Physician Office Visits (Newborn to 21 years old)	No Copay	30%
Well Child Care Immunization (Newborn to 21 years old) (Must be bundled with Well Child Care Visit)	No Copay	No Copay
Well Child Care Laboratory Tests (Newborn to 21 years old) (Must be bundled with Well Child Care Visit)	No Copay	30%
Well Woman Exam – Limited to 1 per CY	No Copay	30%
Screening Services - U.S. Preventive Services Task Force (USPSTF) Recommended	No Copay	No Copay
Cervical Cancer Screening (Pap Smear) – Limited to 1 per CY	No Copay	30%
Chlamydia Screening	No Copay	30%
Colonoscopy Screening	No Copay	30%
Fecal Occult Blood Test (FOBT) Screening	No Copay	30%
Mammography for Breast Cancer Screening Limited to 1 baseline for ages 35 - 39 and 1 per CY for ages 40 and older	No Copay	30%
Osteoporosis Screening (Peripheral DexaScan or Ultrasound of the heel) Limited to 1 per CY	10%	30%
Prostate Specific Antigen (PSA) Screening (Age 50 and older) – Limited to 1 per CY	No Copay	30%
Sigmoidoscopy Screening	No Copay	30%
Tuberculin Test Screening – Limited to 1 per CY	10%	30%
Immunizations (Standard)	No Copay	30%

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Maternity Services

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
Maternity Care	10%	30%
Newborn Circumcision	10%	30%
Newborn Nursery	No Copay	30%
Breast Pumps	No Copay	Not Covered
Interrupted Pregnancy	10%	30%

Contraceptive Management

Contraceptive Implants, when dispensed by a Physician (Does not apply to the Out of Pocket Maximum) Limited to 1 method per period of effectiveness	No Copay	No Copay
Contraceptive Injectables, when dispensed by a Physician (Does not apply to the Out of Pocket Maximum) Limited to 1 method per period of effectiveness	No Copay	No Copay
Contraceptive IUD, when dispensed by a Physician (Does not apply to the Out of Pocket Maximum) Limited to 1 method per period of effectiveness	No Copay	No Copay
Tubal Ligation	No Copay	No Copay
Vasectomy	10%	30%

Diagnostic Testing, Laboratory, and Radiology Services

Allergy Testing	20%	30%
Allergy Treatment	20%	30%
Diagnostic Testing - Inpatient	10%	30%
Diagnostic Testing - Outpatient	20%	30%
Laboratory and Pathology - Inpatient	10%	30%
Laboratory and Pathology - Outpatient	20%	30%
Radiology - Inpatient (Authorization required for PET Scans, CTCA and Dexa Scans)	10%	30%
Radiology - Outpatient (Authorization required for PET Scans, CTCA and Dexa Scans)	20%	30%

Surgical Services

(Certain Surgical Services may Require Prior Authorization)

Anesthesia	10%	30%*
Assistant Surgeon Services	10%	30%*
Cutting Surgery - Inpatient	10%	30%*
Cutting Surgery - Outpatient	10%	30%*

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Surgical Services (Cont.)

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
Non-Cutting Surgery - Inpatient	20%	30%*
Non-Cutting Surgery - Outpatient	20%	30%*
Reconstructive Surgery (Authorization Required)	20%	30%*
Second Opinions (Authorization required for opinions rendered by out-of-state providers)	No Copay	30%
Surgical Supplies	10%	30%*

Organ and Tissue Transplants

(Prior Authorization is required for all Organ and Tissue Transplant treatments)
Services are only available through contracted providers.

Transplant Evaluation	No Copay	Not Covered
Organ Donor Services	20%	30%*
Transplants Coverage limited to Corneal, Heart, Heart and Lung, Kidney, Liver, Lung, Pancreas, Simultaneous Kidney/Pancreas, Small Bowel and Multivisceral, and Stem-Cell (Including Bone Marrow)	No Copay	Not Covered

Hospital and Facility Services

Ambulatory Surgical Center (ASC)	10%	30%*
Hospice Services	No Copay	Not Covered
Hospital Ancillary Services	10%	30%*
Hospital Operating Room	10%	30%*
Hospital Room and Board (Authorization Required)	10%	30%*
Intensive Care Unit/Coronary Care Unit (Authorization Required)	10%	30%*
Intermediate Care Unit (Authorization Required)	10%	30%*
Isolation Care Unit (Authorization Required)	10%	30%*
Outpatient Facility (Authorization Required)	10%	30%*
Skilled Nursing Facility (Authorization Required) Limited to 120 days per CY	10%	30%*

Behavioral Health – Mental Health and Substance Abuse

Hospital and Facility Services - Inpatient (Authorization Required)	10%	30%*
Hospital and Facility Services - Outpatient	10%	30%*
Physician Services - Inpatient	$12 Copay per visit	30%
Physician Services - Outpatient	$12 Copay per visit	30%

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Behavioral Health – Mental Health and Substance Abuse (Cont.)

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
Psychological Testing - Inpatient	10%	30%*
Psychological Testing - Outpatient	20%	30%*

Ancillary Services

Ambulance (Air)	20%*	30%*
Ambulance (Ground)	20%*	30%*
Blood and Blood Products	20%*	30%*
Chemotherapy - Infusion/Injections	20%*	30%*
Dialysis and Supplies	20%*	30%*
Durable Medical Equipment and Supplies (Authorization Required)	20%*	30%*
Durable Medical Equipment - Repair	20%*	30%*
Genetic Testing and Counseling (Authorization Required)	20%*	30%*
Growth Hormone Therapy (Authorization Required)	20%*	30%*
Hearing Evaluation	$12 Copay per visit	30%
Hearing and Vision Appliances	20%*	30%*
Home Health Care - Limited to 150 visits per CY (Authorization Required)	No Copay	30%*
Home IV Therapy	20%*	30%*
Inhalation Therapy	20%*	30%*
Outpatient Injections	20%*	30%*
In Vitro Fertilization (Authorization Required) Limited to one time, 1 cycle per lifetime on plan	20%*	30%*
Medical Foods (Does not apply to the Out of Pocket Maximum)	20%	20%
Orthotics and External Prosthetics and Supplies	20%*	30%*
Orthotics and Prosthetics - Repair and Replacement	20%*	30%*
Physical and Occupational Therapy - Inpatient	10%	30%*
Physical and Occupational Therapy - Outpatient	20%*	30%*
Radiation Therapy - Inpatient	10%	30%*
Radiation Therapy - Outpatient	20%	30%*
Speech Therapy - Inpatient	10%	30%*
Speech Therapy - Outpatient	20%*	30%*
Tempormandibular Joint and Malocclusion of Teeth and Jaw	20%*	30%*

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Pharmacy Coverage Under the Medical Plan

The coverage below is only available under the medical plan if you do not have a pharmacy rider under Family Health Hawaii. If you have coverage for pharmacy benefits under Family Health Hawaii, the benefits below are not covered under the medical plan. Refer to your pharmacy rider for coverage.

Contraceptive - Dispensed by Pharmacy		
Summary of Benefits	**Participating**	**Non-Participating based on Eligible Medical Expense**
Contraceptive Cervical Caps/Diaphragms	No Copay	$10 Per Device
Oral Contraceptive (Generic)	No Copay	20%
Oral Contraceptive (Preferred)	20%	20%
Oral Contraceptive (Other Brand Name)	30%	30%
Contraceptive – Other Methods (Generic)	No Copay	20%
Contraceptive – Other Methods (Preferred)	20%	20%
Contraceptive – Other Methods (Other Brand Name)	30%	30%
Specific Benefits for Diabetes – Dispensed by Pharmacy		
Diabetic Supplies (Generic)	No Copay	No Copay
Diabetic Supplies (Preferred)	No Copay	No Copay
Diabetic Drugs (Generic)	20%	20%
Diabetic Drugs (Preferred)	20%	20%
Diabetic Drugs (Other Brand Name)	30%	30%
Insulin (Preferred)	20%	20%
Insulin (Other Brand Name)	30%	30%
Chemotherapy Drugs – Dispensed by Pharmacy		
Chemotherapy – Oral	No Copay	No Copay
Mail Order Chemotherapy – Oral	No Copay	Not Covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs – Dispensed by Pharmacy		
USPSTF Recommended Drugs	No Copay	No Copay