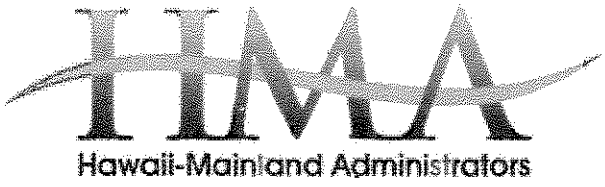
Hawaii Provider Manual

Third Party Administrator: **HMA, LLC**



- **Customer Service**
- **Claims Administration**
- **Medical Management**
- **Provider Services**

HMA, LLC
1440 Kapiolani Boulevard · Honolulu, HI 96814
P.O. Box 135005, Honolulu, HI 96801

☎ (808) 951-4621 • **Toll-Free**: (866) 377-3977
E-FAX: (866) 206-5664

Visit www.hma-hi.com for a copy of our Most Current HMA Provider Manual

2/12/2015

HMA, LLC – CONTACT INFORMATION

Provider Services Department

☎ HOTLINE (808) 441-3460 or Toll Free at (866) 888-5439 or
Main Number: (808) 951-4621 or Toll Free at (866) 377-3977
Provider Services Fax: (866) 206-5664

- Contract Information/Status – MultiPlan 800-919-1173
- Provider Information Updates and Changes

Claims / Client Services Department

☎ (808) 951-4621 or Toll Free at (866) 377-3977

- Confirmation of Eligibility
- Clarification of Plan Benefits
- Claims Status Information

Health Services

☎ (808) 951-4621 or Toll Free at (866) 377-3977

- Inpatient Review
  - (Pre-certification & Concurrent Review)
- Outpatient Surgery Review
- Case Management / Large Case Management
- Ancillary Service Arrangements for
  - Home Health
  - Home IV
  - Durable Medical Equipment

CLAIMS are mailed to:

HAWAII Provider's mail your claims to:

HMA, LLC
PO Box 135005
Honolulu, HI 96801

Honolulu Service Center Location
1440 Kapiolani Boulevard, Suite #1020
Pacific Guardian Tower
Honolulu, HI 96814

PROVIDER PARTICIPATION

HMA – Hawaii Service Center is located at 1440 Kapiolani Blvd #1020 and is staffed with local personnel.

HMA's functions include program management, provider services, member services, medical management, case management and account management. These services are provided from the Hawaii Service Center.

Providers may call HMA's Provider Relations Department regarding Provider Servicing. Register for on-line services at www.hma-hi.com for access to eligibility, benefits, and claims information.

Claims / Client Services is available for member eligibility or claims status.

Health Services goal is to maintain the highest quality of care for HMA members. We contain costs without disrupting the healthcare process. Medical Management is about matching the patient with the most effective level of care available.

HMA's Medical Management program helps eliminate unnecessary procedures, shorten hospital stays, and enhance the delivery of care. We also make sure that the patient's received care is proper for the situation and in the most appropriate environment.

Experience...Quality...Service – The Health Services team is led by a Medical Director and registered nurses. They work together with the local medical community and the client to provide an integrated managed care approach. They bring a high level of expertise, dedication and innovation to our medical management programs. The result is an increased level of care and superior service to our clients.

Portfolio of Services

- Inpatient Review (Pre-Certification & Concurrent Review)
- Outpatient Surgery Review
- Referrals Management
- Case Management
- Mental Health & Substance Abuse Review
- Ancillary Service Arrangements for Home Health, Home IV and Durable Medical Equipment

LISTING OF PLANS ADMINISTERED BY HMA, LLC., HAWAII

HMA, LLC maintains Third Party Administration (TPA) services (claims, adjudication, members/customer services, medical management / pre-certification) for many clients including the groups listed below in Hawaii. This manual contains specific benefit and eligibility information for these clients. Benefits for each client may vary.

Your participation in HMN, however, provides you the additional opportunity to participate as a provider for other HMA, LLC clients and Third Party Administrators. Benefits, eligibility determination and claims submission requirements can be determined for these clients by utilizing the contact information on the member's cards. Also, a client listing containing certain clients contact information is available through an HMN Provider Relations representative at the HMA, LLC. Hawaii Service Center. The information provided in this manual is a condensed explanation of plan benefits. Certain limitations, restrictions, and exclusions may apply.

HMA, LLC. Hawaii TPA Clients:

- AFL Hotel & Restaurant Workers Health and Welfare Trust Fund
- CVS Caremark
- Family Health Hawaii
- Hawaii Teamsters Health and Welfare Trust Fund HMO & PPO
- ILWU Local 142 Health & Welfare Trust (HOTEL)
- Times Supermarket
- UFCW – Hawaii Food Employers Health and Welfare Trust Fund

Hawaii-Mainland Administrators

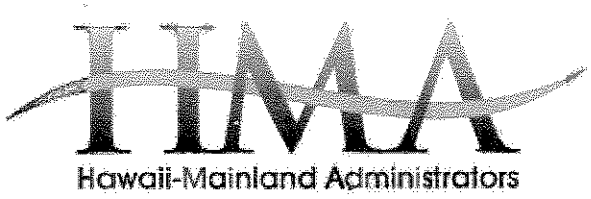
Authorizations and Requirements for the
AFL Hotel and Restaurant Health and Welfare Trust Fund Members
Effective March 01, 2011

The member must call the HMA Health Services Department for Hospital admissions, services or procedures ***before*** the services are given.

PHONE:	**Oahu**	**(808) 951-4621**
	Toll Free	**(866) 377-3977**
FAX:		**(808) 951-4647**

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a reduction of benefits.***

INPATIENT ADMISSION	• All inpatient admissions including acute, skilled and observation stays.
OUTPATIENT SERVICES	• Imaging scans.(MRI, MRA, PET) • Gamma Knife/X Knife • Greater than two (2) OB ultrasounds • Infertility studies and treatment/procedures • In-vitro fertilization • Reconstructive surgery • Weight loss services
OUTPATIENT REHABILITATION SERVICES	• Physical Therapy • Speech Therapy • Occupational Therapy
OTHER MEDICAL SERVICES	• Durable Medical Equipment (DME) • Hospice Care • Home Health Services • Infusion Therapy • Human Growth Hormone • Dialysis • Chemotherapy • Radiation Therapy • Orthotics and Prosthetics • Non-Emergent Out of State Services • Non-Emergent Off Island Travel (Air) • Non-Emergent Off Island Travel (Taxi) (NOTE: Non-Emergent Off Island Travel ONLY for members who do not reside on the island of Oahu and limited within the State of Hawaii
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	• Mental Health Services– require a treatment plan • Substance abuse programs – require a treatment plan
For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.	



Authorization and Requirements for CVS Caremark
Effective June 1, 2012

The Participating Provider, or the member in cases when an out-of-network provider is being accessed, must call the HMA Health Services when your physician plans for surgery, hospitalization or diagnostic tests.

Phone:	**Oahu**	**(808) 951-4621**
Toll Free:		**(866) 377-3977**
Fax:		**(866) 206-5655**

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a reduction of benefits.***

INPATIENT ADMISSION	• All inpatient admissions including acute, skilled and observation stays
OUTPATIENT SERVICES	• Imaging Scans (MRI, MRA, PET, CAT Scan) • Nuclear Cardiac Imaging • In-Vitro Fertilization
OUTPATIENT REHABILIATION SERVICES	• Speech Therapy • Physical Therapy • Occupational Therapy
TRANSPLANT SERVICES	• Kidney • Cornea • Bone Marrow • Liver • Heart • Lung • Heart-Lung • Small Intestine • Pancreas
OTHER MEDICAL SERVICES	• Durable Medical Equipment (DME) • Hospice Care • Home Health Services • Genetic Testing • Bariatric Surgery • Chemotherapy • Dialysis • Radiation Therapy
MENTAL HEALTH / SUBSTANCE ABUSE SERVICES	• Mental Health Services – requires treatment plan • Substance abuse programs – requires treatment plan
For Emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.	

FamilyHealth HAWAII

Prior Authorization Requirements

For All Family Health Hawaii Members

Family Health Hawaii requires a Prior Authorization of hospital admission and various inpatient/outpatient services. The Participating Provider or Member must call the Health Services Department for hospital admissions, Services, or procedures prior to the services being performed.

How to obtain a Prior Authorization:
Please mail or fax a **Prior Authorization Request Form** to our Health Services Department along with clinical documentation at least fifteen (15) business days prior to the planned service, surgery, and/or admission; or within forty-eight (48) hours or one working day, whichever is later of an emergent admission.

Mailing Address	Phone Numbers	Fax Numbers
Family Health Hawaii Health Services Department 1440 Kapiolani Blvd., Suite 1000 Honolulu, Hawaii 96814	**On Oahu:** (808) 457-3277 **Toll-Free:** (855) 206-3277	(808) 206-5655

Prior Authorization:
The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization **may result in a reduction of benefits or payment**. Emergency and maternity admissions do not require Prior Authorizations but HMA Health Services Department must be notified within 48 hours or by the next business day.

Prior Authorization is required for all In-Network, Out-of-Network, and Out-of-State Providers

Services Requiring Prior Authorization

Note: This list is subject to change at any time and without prior notice. Contact us for a current list.

Inpatient Hospital Admission	All inpatient admissions including acute, skilled and observation stays	
Outpatient Diagnostic, Therapeutic Services & Imaging Scans	• Chemotherapy • Dialysis • Gamma Knife or X-knife Procedure • MRA - Magnetic Resonance Angiogram • MRI - Magnetic Resonance Imaging • Myelogram	• OB Ultrasound (3 or more require approval) • Occupational Therapy • PET - Positron Emission Tomography • Physical Therapy • Radiation Therapy • Speech Therapy
Home Health Services	• Durable Medical Equipment • Home Health Services	
Miscellaneous	• Bariatric • Human Growth Hormone • Hospice	• Hyperbaric Oxygen Treatment • In Vitro Fertilization (1 per lifetime) • Non-Emergent Off-Island Travel Benefit
Plastic /Reconstructive Surgery	• All Plastic / Reconstruction Surgeries	
Organ and Tissue Transplants	• Allogeneic Stem-Cell Transplant, Autologous Stem-Cell Transplant, and Reduced Conditioning for Allogeneic Stem-Cell • Corneal Transplant • Heart Transplant • Heart/Lung Transplant	• Kidney Transplant • Liver Transplant • Lung and Lobar Lung Transplant • Pancreas Transplant • Simultaneous Kidney/Pancreas Transplant • Small Bowel Transplant • Small Bowel/Liver and Multivisceral Transplant
Alternative Treatment	• All Alternative Treatment Plans	

Hawaii-Mainland Administrators

Authorizations and Requirements for
Hawaii Teamsters Health and Welfare Trust Fund Members
Effective March 01, 2011

The member must call the HMA Health Services Department for Hospital admissions, services or procedures ***before*** the services are given.

Phone:	**Oahu**	**(808) 951-4621**
	Toll Free	**(866) 377-3977**
Right-FAX:		**(866) 206-5655**

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a reduction of benefits.***

INPATIENT ADMISSION	▪ All inpatient admissions including acute, skilled and observation stays.
OUTPATIENT SERVICES	▪ Imaging scans (MRI, MRA, PET) ▪ Gamma Knife / X Knife ▪ Greater than two (2) OB ultrasounds ▪ Infertility studies and treatment / procedures ▪ In-vitro fertilization ▪ Reconstructive surgery ▪ Weight loss services
OUTPATIENT REHABILITATION SERVICES	▪ Physical Therapy ▪ Speech Therapy ▪ Occupational Therapy
OTHER MEDICAL SERVICES	▪ Durable Medical Equipment (DME) ▪ Hospice Care ▪ Home Health Services ▪ Infusion Therapy ▪ Human Growth Hormone ▪ Dialysis ▪ Chemotherapy ▪ Radiation Therapy ▪ Orthotics and Prosthetics ▪ Non-Emergent Out of State Services ▪ Non-Emergent Off Island Travel (Air) ▪ Non-Emergent Off Island Travel (Taxi) (NOTE: Non-Emergent Off Island Travel ONLY for members who do not reside on the island of Oahu and limited within the State of Hawaii
MENTAL HEALTH / SUBSTANCE ABUSE SERVICES	▪ Mental Health Services – require a treatment plan ▪ Substance Abuse Programs – require a treatment plan
For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.	

Authorizations and Requirements for
ILWU – Hotel Health and Welfare Trust Members
Effective February 1, 2011

The member must call the HMA Health Services Department for Hospital admissions, services or procedures ***before*** the services are given.

PHONE: **(808) 951-4621**
Toll Free: **(866) 377-3977**
FAX: **(866) 206-5655**

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a reduction of benefits.***

INPATIENT ADMISSION	• All inpatient admissions including acute, skilled and observation stays.
OUTPATIENT SERVICES	• Imaging scans.(MRI, MRA, PET) • Gamma Knife / X Knife • Greater than two (2) OB ultrasounds • Infertility studies and treatment/procedures • In-vitro fertilization • Reconstructive surgery • Weight loss services
OUTPATIENT REHABILITATION SERVICES	• Physical Therapy • Speech Therapy • Occupational Therapy
OTHER MEDICAL SERVICES	• Durable Medical Equipment (DME) • Hospice • Home Health Services • Infusion Therapy • Human Growth Hormone • Dialysis • Chemotherapy • Radiation Therapy • Orthotics and Prosthetics • Non-Emergent Out of State Services • Non-Emergent Off Island Travel (Ferry)-members residing on the island of Lanai • Non-Emergent Inter-Island Travel (Air) • Non-Emergent Inter-Island Travel (Taxi) (NOTE: Non-Emergent Inter-Island Travel is ONLY for members who do not reside on the Island of Oahu.)
For emergency or maternity admissions, you must notify the HMA Health Services Department within 48 hours or by the next business day.	

Hawaii-Mainland Administrators

Prior Authorization Requirements for Times Supermarket Members
Effective January 1, 2015

The member must call the HMA Health Services Department for hospital admissions, services or procedures ***before*** the services are provided.

PHONE: (808) 951-4621
TOLL FREE: (866) 377-3977
FAX: (808) 206-5655

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a benefit reduction***. Emergency and maternity admissions do not require prior authorization but HMA Health Services Department must be notified within 48 hours or by the next business day.

INPATIENT ADMISSION	All inpatient admissions including acute, skilled and observation stays.
OUTPATIENT SERVICES	o Imaging Scans (MRI, MRA & PET) o Gamma Knife or X-knife Procedure o Greater than two (2) OB Ultrasounds o Reconstructive Surgery o In Vitro Fertilization (1 per lifetime) o Weight Loss Services
OUTPATIENT REHABILITATION SERVICES	o Physical Therapy – after initial 10 visits o Occupational Therapy – after initial 10 visits

OTHER MEDICAL BENEFITS	o Durable Medical Equipment & Prosthetics – over $500; rentals over $100
	o All Transplants
	o Home Infusion Therapy
	o Home Health Services – after initial 12 visits
	o Hospice
	o Dialysis
	o Injectables
	o Chemotherapy
	o Radiotherapy
	o Human Growth Hormone
	o Genetic Testing
	o Inpatient/Outpatient surgical services
	  o Autologous chondrocyte implantation
	  o Bariatric surgery
	  o Blepharoplasty
	  o Panniculectomy
	  o Thoracic sympathectomy for hyperhidrosis
	  o Treatment of varicose veins
	  o Hyperbaric oxygen treatment

MENTAL HEALTH	o Mental Health Services – Neuropsychological Testing (NPT)

Hawaii-Mainland Administrators

Prior Authorization Requirements for UFCW Hawaii Food Employers Health and Welfare Trust Fund Members Effective June 1, 2012

The member must call the HMA Health Services Department for elective hospital admissions, services or procedures ***before*** the services are provided.

PHONE: (808) 951- 4621
Toll Free: (866) 377-3977
FAX: (808) 951-4647

Prior Authorization: The following services require prior authorization through the Health Services Department. Failure to obtain prior authorization ***may result in a benefit reduction***. Emergency and maternity admissions do not require prior authorization but HMA Health Services Department must be notified within 48 hours or by the next working day.

All non-emergency out-of-state services require prior authorization.

ELECTIVE INPATIENT ADMISSION	All ***elective*** inpatient admissions including acute, skilled and observation stays.
OUTPATIENT DIAGNOSTIC, THERAPEUTIC SERVICES & IMAGING SCANS	o Chemotherapy o Radiotherapy o Physical Therapy o Speech Therapy o Occupational Therapy o Dialysis o Mental Health/Substance Abuse Services o MRI -Magnetic Resonance Imaging o MRA-Magnetic Resonance Angiogram o PET-Positron Emission Tomography o Gamma Knife or X-knife Procedure o OB Ultrasound (limit 2 per pregnancy) o Myelogram
HOME HEALTH SERVICES	o Durable Medical Equipment o Home Health Services
MISCELLANEOUS	o Smoking Cessation o Human Growth Hormone o In Vitro Fertilization (1 per lifetime) o Hospital o Surrogacy Health Benefits o Non-Emergency Out of State Services
OUTPATIENT SURGERY (see listing below)	The following surgeries are covered benefits if done on an outpatient basis, but a second surgical opinion may be required if a Health Services Review indicates the requested procedure may not be medically necessary or not a covered benefit. In this case if you do not call and obtain the necessary second surgical opinion or pre-admission review, your benefit payments will be reduced.
Endoscopic Procedures	o Bronchoscopy o Colonoscopy o Cystoscopy o ERCP-Endoscopic Retrograde o Cholangiopancreatography o Esophagoscopy o Laparoscopy o Sigmoidoscopy o Duodonoscopy

Hawaii-Mainland Administrators

Prior Authorization Requirements for UFCW Hawaii Food Employers Health and Welfare Trust Fund Members Effective June 1, 2012

Gastrointestinal Surgery	○ Inguinal hernia repair ○ Liver biopsy, percutaneous ○ Hemorrhoidectomy	○ Rectal polypectomy ○ Umbilical hernia repair
General Surgery	○ Breast biopsy ○ Cervical node biopsy ○ Excision of breast mass (cyst) ○ Excision of foreign body (superficial) ○ Excision of lipoma ○ Excision of mass ○ Gall bladder surgery ○ Hysterectomy	○ Excision of skin lesion ○ Muscle biopsy ○ Neurectomy ○ Neurolysis, simple ○ Varicose veins, ligation and excision ○ Laparotomy ○ Laparoscopic procedures ○ Revision of colostomy
Gynecologic Surgery	○ Abortion (1st trimester) – limit of two per lifetime ○ Dilation and Curettage (D&C) ○ Hymenotomy	○ Marsupialization of Bartholin's cyst ○ Sterilization or reversal is not a covered benefit
Opthalmic Surgery	○ Excision of cataract ○ Other elective eye surgery	○ Iridectomy
Orthopedic Surgery	○ Arthroscopy ○ Fracture, closed reduction ○ Ganglionectomy ○ Hammertoe Operation ○ Manipulation of the joints ○ Removal of bunion	○ Meniscectomy ○ Osteotomy ○ Phalangectomy ○ Tendon sheath repair ○ Tenotomy
Otolaryngic Surgery	○ Myringoplasty ○ Myringotomy ○ Nasal polypectomy	○ Septoplasty ○ Tympanoplasty
Plastic /Reconstructive Surgery	○ Blepharoplasty ○ Otoplasty ○ Rhinoplasty ○ Reconstructive Surgery	○ Rhytidectomy ○ Scar revision ○ Septal reconstruction ○ Skin graft ○ Breast reduction/ augmentation
Urologic Surgery	○ Circumcision (if performed after discharge from birth) ○ Meatotomy ○ Orchiectomy	○ Sterilization or reversal is not covered ○ Testicular biopsy ○ Urethral dilation ○ Transurethral Resection Prostatectomy

AFL HOTEL & RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND
WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self- Funded Medical Plan	
	Participating Provider	**Non Participating Provider**
Annual Deductible	No Deductible	No Deductible
Annual Co-payment	$2,800.00 per person $8,400.00 per family (3 or more)	$2,800.00 per person $8,400.00 per family (3 or more)
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF visits (Hosp inpt visits limited to one (1) per day)	90% of E.C.	80% of E.C.*
Well-Child Care 0-2 years (8 visits)	90% of E.C.	80% of E.C.*
Well-Child (1 visit each during ages 2-5 years)	90% of E.C.	80% of E.C.*
Limited to the following tests thru age five: two tuberculin tests, two blood tests (hemoglobin & hematocrit) and one urinalysis		
Immunizations	90% of E.C. (Includes Well-Child Care)	80% of E.C.* (Includes Well-Child Care)
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumonia.		
HPV is covered for females (eff 05/01/07) and males (eff 07/01/14) when the first dose is administered to an 11-12 year old beneficiary with the second or third dose administered prior to 13 years old. For beneficiaries ages 13-18 years of age, the HPV vaccine is covered at 50% E.C. for par and non-par providers when the first dose is administered to a 13-18 year old beneficiary with the second and third dose administered prior to 19 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administrated by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C. (365 days maximum per Calendar Year)	80% of E.C.*
Intensive Care Unit, Coronary Care Unit	100% of E.C.	80% of E.C.*
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	80% of E.C.*
Life Bed (Effective 01/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day *
Ancillary Services	90% of E.C.	80% of E.C.*
Emergency Room	100% of E.C. **Not covered if not a true emergency**	80% of E.C. *
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays, and life bed	
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	100% of E.C.	80% of E.C.*
Anesthesiologist	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Reconstructive surgery	
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C.*

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND
WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self- Funded Medical Plan	
	Participating Provider	**Non Participating Provider**
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C.*
Mammography (Limited to one (1) baseline mammogram ages 35-39 and one mammogram every 12 months for ages 40 and above)	100% of E.C.	80% of E.C.*
Routine Pap Smear (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C.*
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	100% of E.C.	80% of E.C*
PRIOR AUTHORIZATION REQUIRED:	Imaging Scans (MRI,MRA,PET) Gamma Knife/X Knife Greater than two (2) OB ultrasounds	
MATERNITY SERVICES		
Physicians Services	90% of E.C.	80% of E.C.*
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	80% of E.C.*
Birthing Center Services	100% of E.C.	80% of E.C.*
In Vitro Fertilization (Limited to one (1) procedure per lifetime)	90% of E.C. Physicians Services	80% of E.C.*
	100% of E.C. Labs & X-rays	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Infertility studies and treatment/procedures In-vitro fertilization	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	90% of E.C.	80% of E.C.*
Outpatient Physician Services	90% of E.C.	80% of E.C.*
Psychological Testing	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Mental Health Services - require a treatment plan Substance Abuse Programs - require a treatment plan	
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	
HOSPICE CARE SERVICES	(Up to 150 days of hospice services for a terminal illness)	
	100% of E.C.	Not Covered
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
HOME HEALTH CARE	(Up to 150 home health care visits per calendar year)	
	100% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND
WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self- Funded Medical Plan	
	Participating Provider	Non Participating Provider
AMBULANCE SERVICES		
	Not covered if not a true emergency	
Automobile	90% of E.C.	80% of E.C.*
Air	80% of E.C.	80% of E.C.*
For transportation within the State of HI & United States of America when facilities within the State of HI are not equipped to furnish treatment.		
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	100% of E.C.	80% of E.C.*
Appliances & Equipment (DME) Includes hearing aids - one device per ear every five (5) years	80% of E.C.	80% of E.C.*
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C.	80% of E.C.*
Evaluations for Hearing Aids	80% of E.C.	80% of E.C*.
Chemotherapy	80% of E.C.	80% of E.C.*
Dialysis & Supplies	80% of E.C. (eff. 06/01/13 - E.C. for dialysis at 150% of Medicare eligible)	80% of E.C.*
Organ Donor Services	80% of E.C.	80% of E.C.*
Outpatient Injections	80% of E.C.	80% of E.C.*
Physical & Occupational Therapy	80% of E.C.	80% of E.C.*
Speech Therapy	80% of E.C.	80% of E.C.*
Nutrient Solutions Required for Primary Diet for Hereditary Metabolic Disorders	80% of E.C.	80% of E.C. *
IUD Implant for Contraceptive Purposes (Limited to one (1) IUD implant every five (5) years)	50% of E.C.	50% of E.C. *
PRIOR AUTHORIZATION REQUIRED:	Weight loss services Physical Therapy Speech Therapy Occupational Therapy Durable Medical Equipment (DME) Infusion Therapy Human Growth Hormone Dialysis Chemo/Radiation Therapy Orthotics and Prosthetics	

Non-Emergency Inter-Island Travel Benefit for all Beneficiaries who do not reside on the island of Oahu (eff. 9/1/12)

Air Travel: Reimbursement of up to $200.00, or the actual cost of the fare, whichever is less.
Taxi: Reimbursement to and from the airport of up to $50.00, or the actual cost of the fare, whichever is less, on the island of Oahu.
(Plan will reimburse qualified travel expenses for one accompanying parent/guardian up to the benefit limitation for a minor child under 18 yrs of age)

PRIOR AUTHORIZATION REQUIRED: Non-Emergency Inter-Island Travel Benefit

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND
(Retirees)

Benefits	Comprehensive Medical Plan	
	Participating Provider	**Non Participating Provider**
Annual Deductible	No Deductible	No Deductible
Annual Co-payment	$2,800.00 per person $8,400.00 per family (3 or more)	$2,800.00 per person $8,400.00 per family (3 or more)
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF, visits (Hosp inpt visits limited to one (1) per day)	90% of E.C.	80% of E.C.*
Well-Child Care 0-2 years (8 visits)	90% of E.C.	80% of E.C.*
Well-Child (1 visit each during ages 2-5 years)	90% of E.C.	80% of E.C.*
Limited to the following tests thru age five (5): two tuberculin tests, two blood tests (hemoglobin & hematocrit) and one urinalysis		
Immunizations	90% of E.C. (Includes Well-Child Care)	80% of E.C.* (Includes Well-Child Care)
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumonia.		
HPV is covered for females (eff 05/01/07) and males (eff 07/01/14) when the first dose is administered to an 11-12 year old beneficiary with the second or third dose administered prior to 13 years old. For beneficiaries ages 13-18 years of age, the HPV vaccine is covered at 50% E.C. for par and non-par providers when the first dose is administered to a 13-18 year old beneficiary with the second and third dose administered prior to 19 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administrated by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C.	80% of E.C.*
	(365 days maximum per Calendar Year)	
Intensive Care Unit, Coronary Care Unit	100% of E.C.	80% of E.C.*
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	80% of E.C.*
Life Bed (Effective 01/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day *
Ancillary Services	90% of E.C.	80% of E.C.*
Emergency Room	100% of E.C.	80% of E.C. *
	Not covered if not a true emergency	
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays, and life bed.	
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	100% of E.C.	80% of E.C.*
Anesthesiologist	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Reconstructive surgery	
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C.*

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND
(Retirees)

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non Participating Provider
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C.*
Mammography (Limited to one (1) baseline mammogram age 35-39 and one mammogram every 12 months for ages 40 and above)	100% of E.C.	80% of E.C.*
Routine Pap Smear (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C.*
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	100% of E.C.	80% of E.C*
PRIOR AUTHORIZATION REQUIRED:	Imaging Scans (MRI,MRA,PET) Gamma Knife/X Knife Greater than two (2) OB ultrasounds	
MATERNITY SERVICES		
Physicians Services	90% of E.C.	80% of E.C.*
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	80% of E.C.*
Birthing Center Services	100% of E.C.	80% of E.C.*
In Vitro Fertilization (Limited to one procedure per lifetime)	90% of E.C. Physicians Services	80% of E.C.*
	100% of E.C. Labs & X-rays	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Infertility studies and treatment/procedures In-vitro fertilization	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	90% of E.C.	80% of E.C.*
Outpatient Physician Services	90% of E.C.	80% of E.C.*
Psychological Testing	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Mental Health Services - require a treatment plan Substance Abuse Programs - require a treatment plan	
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	
HOSPICE CARE SERVICES	(Up to 150 days of hospice services for a terminal illness)	
	100% of E.C.	Not Covered
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
HOME HEALTH CARE	(Up to 150 home health care visits per calendar year)	
	100% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST FUND
(Retirees)

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non Participating Provider
AMBULANCE SERVICES	**Not covered if not a true emergency**	
Automobile	90% of E.C.	80% of E.C.*
Air	80% of E.C.	80% of E.C.*
For transportation within the State of HI & United States of America when facilities within the State of HI are not equipped to furnish treatment.		
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	100% of E.C.	80% of E.C.*
Appliances & Equipment (DME) Includes hearing aids - one (1) device per ear every five (5) years	80% of E.C.	80% of E.C.*
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C.	80% of E.C.*
Evaluations for Hearing Aids	80% of E.C.	80% of E.C*.
Chemotherapy	80% of E.C.	80% of E.C.*
Dialysis & Supplies	80% of E.C.	80% of E.C.*
Organ Donor Services	80% of E.C.	80% of E.C.*
Outpatient Injections	80% of E.C.	80% of E.C.*
Physical & Occupational Therapy	80% of E.C.	80% of E.C.*
Speech Therapy	80% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Weight loss services Physical Therapy Speech Therapy Occupational Therapy Durable Medical Equipment (DME) Infusion Therapy Human Growth Hormone Dialysis Chemo/Radiation Therapy Orthotics and Prosthetics	

Non-Emergency Inter-Island Travel Benefit for all beneficiaries who do not reside on the island of Oahu (eff. 9/1/12)

Air Travel: Reimbursement of up to $200, or the actual cost of the fare, whichever is less.
Taxi: Reimbursement to and from the airport of up to $50, or the actual cost of the fare, whichever is less, on the island of Oahu.
(Plan will reimburse qualified travel expenses for one accompanying parent/guardian up to the benefit limitation for a minor child under 18 yrs of age)

PRIOR AUTHORIZATION REQUIRED: Non-Emergency Inter-Island Travel Benefit

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

CVS CAREMARK

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non Participating Provider
Annual Deductible	$300 per person $600 per individual & spouse, domestic partner or child $900 per family	$300 per person $600 per individual & spouse, domestic partner or child $900 per family
Annual Co-payment Maximum	$3000 per person per plan year $6000 per individual & spouse, domestic partner or child per plan year $9000 per family (3 or more) per plan year	$3000 per person per plan year $6000 per individual & spouse, domestic partner or child per plan year $9000 per family (3 or more) per plan year
Lifetime Maximum	None	None
Dependent Coverage	To age 26	
PHYSICIAN SERVICES		
ER Visit	80% after annual deductible	80% after annual deductible*
Consultation / Hospital Visit	80% after annual deductible	70% after annual deductible*
House Calls	80% after annual deductible	70% after annual deductible*
OFFICE VISITS		
Adult Immunizations	100% coverage annual deductible does not apply	NOT COVERED
Allergist and Dermatologist	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Asthma Education	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Diabetes Education	80% after annual deductible (1 pre-assessment, 5 individual and 7 group sessions)	70% after annual deductible*
Hospital Based Clinic Visits	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Nutritional Counseling	100% coverage less $20 copayment, annual deductible does not apply	NOT COVERED
(First 3 visits and 3 subsequent visits are covered per member per plan year are covered when prescribed by physician for treatment of illness)		
Minute Clinic Office Visit and Biometric Screening includes: screening for blood pressure, and lipid disorders, diabetes (fasting blood sugar) and body mass index	100% coverage annual deductible does not apply	NOT APPLICABLE
Primary Care Office Visits - Preventive Visit	100% coverage annual deductible does not apply	NOT COVERED
(One routine adult P.E. and one routine Gyn exam per plan year per member will be covered)		
Primary Care Office Visits - Sick Visit	100% coverage less $20 copayment, annual deductibles does not apply	70% after annual deductible*
Pediatric Office Visits (Well-Child Office Visits) 7 exams in the first 12 months 3 exams in the second (2nd) 12 months 3 exams in the third (3rd) 12 months 1 exam per plan year from 36 months - age 5	100% coverage annual deductibles does not apply	100% coverage annual deductible does not apply*
From age 6 to age 18 - (1) exam per plan year	100% coverage annual deductibles does not apply	70% after annual deductible*
Pediatric Office Visits - Sick Visit	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Pediatric Immunizations	100% coverage annual deductible does not apply	70% after annual deductible*
Specialist Visits (Routine & Non-routine Visits)	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Urgent Care Center Visits	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*

NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

*Member owes any difference between the actual charges and eligible charges (E.C.)

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non Participating Provider
PREVENTIVE IMAGING, LAB AND MACHINE TESTS (Inpatient / Outpatient)		
Imaging / Lab tests other than mammograms, pap smears, bone densitometry, hearing tests, and biometric screening; includes coverage for annual Prostate Antigen (PSA) test for men (age 45 or earlier due to family history)	100% coverage annual deductible does not apply	NOT COVERED
Biometric Screening (at a MinuteClinic)		
Primary biometric screening	100% coverage annual deductible does not apply	NOT APPLICABLE
Biometric Screening at a Provider other than MinuteClinic		
Primary and Secondary biometric screening	100% coverage annual deductible does not apply	NOT COVERED
Subsequent biometric screening	80% after annual deductible	70% after annual deductible*
Hearing Test (Preventive Services)	100% coverage annual deductible does not apply	70% coverage annual deductible does not apply*
(Covered when rendered during a Well Child Office Visit; Routine hearing tests are NOT covered for members aged 20 and over)		
Diagnostic Hearing Test	80% coverage annual deductible does not apply	70% coverage annual deductible does not apply*
Mammogram (Preventive Services)	100% coverage annual deductible does not apply	70% after annual deductible*
(Baseline between ages 35-40; annual mammogram beginning at age 40 or earlier due to family history)		
Diagnostic Mammogram	100% coverage annual deductible does not apply	70% after annual deductible*
Subsequent Mammgrams	80% after annual deductible	70% after annual deductible*
Pap Smear (Preventive Services)	100% coverage annual deductible does not apply	NOT COVERED
Diagnostic Pap Smear	100% coverage annual deductible does not apply	70% after annual deductible*
Subsequent Pap Smear	80% after annual deductible	70% after annual deductible*
Bone Densitometry (Preventive Services)	100% coverage annual deductile does not apply	NOT COVERED
Diagnostic Bone Densitometry	100% coverage annual deductile does not apply	NOT COVERED
Subsequent Bone Densitometry	80% after annual deductible	70% after annual deductible*
HPV DNA Test	100% coverage annual deductible does not apply	70% after annual deductible*
High risk HPV DNA testing every 3 years for women with normal cytology results who are 30 or older.		
CHIROPRACTIC MEDICINE	80% after annual deductible	70% after annual deductible*
	(Benefit maximum $1000 per plan year for all chiropractic services excluding x-rays)	
DIAGNOSTIC IMAGING, LAB AND MACHINE TESTS		
Inpatient, Outpatient Hospital Facility (includes Allergy testing), Outpatient Non-Hospital Facility (includes Allergy testing)	80% after annual deductible	70% after annual deductible*
PRIOR AUTHORIZATION REQUIRED:	Required for Specific Services - Call HMA for more information	
COLONOSCOPY SERVICES		
Preventive Colonoscopy	100% coverage annual deductible does not apply	NOT COVERED
Diagnostic Colonoscopy	100% coverage annual deductible does not apply	70% after annual deductible*
Subsequent Colonoscopy	80% after annual deductible	70% after annual deductible*
SURGERY SERVICES		
Inpatient Services	80% after annual deductible	70% after annual deductible*
Outpatient Services	80% after annual deductible	70% after annual deductible*
PRIOR AUTHORIZATION REQUIRED:	Required for Specific Services - Call HMA for more information	
HOSPITAL INPATIENT SERVICES	80% after annual deductible	70% after annual deductible*
(Unlimited days at general hospital or a specialty hospital; maximum of 45 days per plan year for physical rehabilitation)		
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays	
PREGNANCY, NURSERY CARE & INTERRUPTED PREGNANCY SERVICES		
Pregnancy - Initial Visit	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Pre-natal and Post-partum Office Visits	100% coverage annual deductible does not apply	70% after annual deductible*
Outpatient Imaging, Lab or Machine Tests	80% after annual deductible	70% after annual deductible*
Delivery and all inpatient services	80% after annual deductible	70% after annual deductible*
Elective and induced abortions (Limited to (2) per member per lifetime)	100% coverage less $20 copayment	70% after annual deductible*

NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

*Member owes any difference between the actual charges and eligible charges (E.C.)

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non Participating Provider
HOME HEALTH CARE	100% after annual deductible	70% after annual deductible*
	(Up to 120 visits per plan year)	
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	
HOSPICE CARE SERVICES	80% after annual deductible	70% after annual deductible*
	(Up to 120 visits per member per lifetime)	
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
SKILLED NURSING FACILITY	80% after annual deductible	70% after annual deductible*
	(Up to a maximum of 100 days per member per plan year)	
Doctor Visits	80% after annual deductible	70% after annual deductible*
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	
AMBULANCE SERVICES		
Ground (per occurrence)	80% after annual deductible	80% after annual deductible*
Air/Water (per occurrence)	80% after annual deductible	80% after annual deductible*
CHEMICAL DEPENDENCY TREATMENT		
Inpatient, Chemical Dependency Treatment Facility (Inpatient) ~Detoxification: unlimited days per plan year ~Rehabilitation: unlimited days per plan year	80% after annual deductible	70% after annual deductible*
Outpatient, Chemical Dependency Treatment Facility (Outpatient), Intermediate Care Services	80% after annual deductible	70% after annual deductible*
Provider's Office / In Your Home	100% coverage less $20 copayment	70% after annual deductible*
PRIOR AUTHORIZATION REQUIRED:	Substance Abuse Services - require a treatment plan	
MENTAL ILLNESS SERVICES		
Inpatient	80% after annual deductible	70% after annual deductible*
Outpatient Mental Health / Intermediate Care Services	80% after annual deductible	70% after annual deductible*
Provider's Office / In Your Home	100% coverage less $20 copayment	70% after annual deductible*
PRIOR AUTHORIZATION REQUIRED:	Inpatient Mental Health Services - require a treatment plan	
PRESCRIPTION DRUGS DISPENSED & ADMINISTERED BY A LICENSED HEALTH CARE PROVIDER (OTHER THAN A RETAIL OR ONLINE PHARMACY)		
Injectable Drugs - includes chemotherapy drugs used for other than cancer tx.	80% after annual deductible	70% after annual deductible*
Infused Drugs - includes chemotherapy drugs used for other than cancer tx.	80% after annual deductible	70% after annual deductible*
Anti-Neoplastic (chemotherapy) Drugs for Cancer Treatment - limited to injectable & infused anti-neoplastic drugs used for cancer tx.	80% after annual deductible	70% after annual deductible*
OTHER BENEFITS		
Blood and Blood Products	80% after annual deductible	70% after annual deductible*
Cardiac Rehabilitation (Unlimited Visits)	80% after annual deductible	70% after annual deductible*
Chemotherapy - Inpatient, Outpatient and in a Doctor's Office	80% after annual deductible	70% after annual deductible*
Contraceptive Implants and IUDs, and Diaphragms/Cervical Caps (Per device)	100% coverage deductible does not apply	70% after annual deductible*
Hemodialysis Services (Inpatient, Outpatient, In Your Home)	80% after annual deductible	70% after annual deductible*
Hemophilia Services - Outpatient	80% after annual deductible	70% after annual deductible*
Hemophilia Services - Doctor's Office	100% after annual deductible less $20 copayment	100% after annual deductible less $20 copayment*

NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

*Member owes any difference between the actual charges and eligible charges (E.C.)

Benefits	Comprehensive Medical Plan	
OTHER BENEFITS (cont'd)	**Participating Provider**	**Non Participating Provider**
Human Leukocyte Antigen Testing	80% after annual deductible	70% after annual deductible*
Infertility Services	80% after annual deductible (Limited to one in-vitro cycle per lifetime)	70% after annual deductible*
Infusion Therapy - Inpatient, Outpatient and In Doctor's Office/Your Home	80% after annual deductible	70% after annual deductible*
Lyme Disease Diagnosis and Treatment	Coverage varies based on type of service. Call HMA for more information.	
Medical Equipment, Medical Supplies, Enteral Formula & Food, and Prosthetic Devices:		
Inpatient Coverage	80% after annual deductible	70% after annual deductible*
Outpatient	80% after annual deductible	70% after annual deductible*
Certain diabetic equipment/supplies which are available for purchase at CVS pharmacies is excluded)		
Enteral Formula - delivered through a feeding tube	80% after annual deductible (Must be sole source of nutrition)	70% after annual deductible*
Enteral Formula or Food - taken orally	80% after annual deductible	70% after annual deductible*
*Hearing Aid Services	80% after annual deductible (Limited to one hearing aid per ear every (60) months)	70% after annual deductible*
Organ Transplants	80% after annual deductible	70% after annual deductible*
Physical & Occupational Therapy (Inpatient, Outpatient, Doctor/Therapist Office)	80% after annual deductible	70% after annual deductible*
Podiatrist Services	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Radiation Therapy (Inpatient/Outpatient)	80% after annual deductible	70% after annual deductible*
Respiratory Therapy	80% after annual deductible	70% after annual deductible*
Speech Therapy (Outpatient)	80% after annual deductible	70% after annual deductible*
Speech Therapy (Doctor/Therapist Office)	100% coverage less $20 copayment, annual deductible does not apply	70% after annual deductible*
Tobacco use screening and interventions For all women, and expanded conseling for pregnant tobacco users	100% coverage annual deductible does not apply	NOT COVERED
PRIOR AUTHORIZATION REQUIRED:	Infertility Services In-vitro fertilization Physical Therapy Speech Therapy Occupational Therapy Organ Transplants Durable Medical Equipment (DME) Medical Equipment / Medical Supplies Prosthetic Devices Bariatric Surgery Genetic Testing Dialysis Chemo/Radiation Therapy Enteral Formula & Food	
TEMPORO-MANDIBULAR JOINT DISORDER (TMJ) SERVICES	Coverage varies based on type of TMJ service. Call HMA for more information.	
VISION CARE SERVICES		
Medically Necessary eye exams are covered	100% coverage less $20 copayment, annual deductible does not apply (Routine eye exams are NOT covered)	70% after annual deductible*

NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

*Member owes any difference between the actual charges and eligible charges (E.C.)

FAMILY HEALTH HAWAII

FamilyHealth
HAWAII

HIintegrative Care

Schedule of Benefits: Health Insurance Plan (Large Group)

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.

HIintegrative Care

This supplemental rider covers certain integrated care benefits. When the member elects to access these integrated care benefits, they may be obtained In-Network or Out-of-Network. Family Health Hawaii encourages our members to use a participating Provider to help ensure a lower Out-of-Pocket cost to the member.

You pay the specialty care visit co-payment or coinsurance listed below in the Summary of Benefits for services received under this integrated care services rider. These co-payments or coinsurance are not subject to your annual deductible and do not accumulate towards your out-of-pocket maximum. There is a Calendar Year Benefit Maximum for care obtained under the Integrated Care Rider. After you reach the benefit maximum, we will not cover any more services under this rider for the rest of the calendar year. It is the member's responsibility to pay the full amount of any charges incurred for services received that exceeds the benefit maximum per calendar year. The Family Health Hawaii Integrated Care Rider is a geographically limited plan, which means that Coverage is limited to integrated care services obtained in Hawai'i.

This Supplemental Rider has been sold to your employer's company by Family Health Hawaii. These Benefits will end if the member leaves the Group through which this Rider is issued or the member no longer meets the participation requirements which makes the member eligible for the Benefits under this Rider.

All Coverage provided under this Supplemental Rider is subject to the restriction of the Eligible Charge maximum for each Care Service. The Eligible Medical Expense (EME*) = the lesser of the Contracted Fee or the Billed Amount (If there is No Contracted Fee, then 90% of Medicare is used to determine that component of the EME).

Integrative Care Rider Services

- Chiropractic
- Acupuncture
- Massage Therapy
- Naturopathic
- Bereavement
- Respite
- Cardiac and Pulmonary Rehabilitation
- TMJ (Temporomandibular) Treatment

Coverage Under the Integrative Care Rider

Chiropractic, Acupuncture, Naturopathic, and Massage Therapy have a Calendar year Benefit Maximum of **$650.00** paid by Family Health Hawaii for any and all Chiropractic, Acupuncture, Naturopathic and Massage Therapy Care Services Covered under this section of the Rider.

1. **Chiropractic** - We cover care that is determined to be medically necessary. Coverage is provided for Care Services rendered by a Chiropractor, which may include benefits in any one, up to all, of the following four categories:

Covered Services	In-Network	Out-of-Network
Spinal Manipulation	$15	$25
Physical Therapy	$10	$15
Office Visit (Examination)	$10	$15
X-Rays (First Set, additional sets are not covered)	50% of EC	Not Covered

2. **Acupuncture** - Coverage provided for the following Acupuncture services. Each is subject to a Co-Pay per visit.

Covered Services	In-Network	Out-of-Network
Evaluation and Management	$15	$25
Acupuncture	$15	$25
Electro-Acupuncture	$15	$25

3. **Massage Therapy** - Covered services involves the manipulation of soft tissue structures of the body to help pain, muscle discomfort and stress by helping promote health and wellness. We cover up to 6 visits per calendar year. A prescription is required from your treating Physician or Chiropractor. Covered services include:

Covered Services	In-Network	Out-of-Network
Evaluation and Management	20% Co-Pay per visit	Not Covered

HIintegrative Care

4. **Naturopathic** - Is a holistic approach to the diagnosis, treatment, and prevention of illness. The Coverage is subject to a Co-Pay per visit. Dispensed items are excluded from Coverage. Also excluded are Laboratory Tests and other Diagnostic Studies, whether performed in the office or sent out by the Naturopath. Covered services include:

Covered Services	In-Network	Out-of-Network
Initial Office Visits (Examinations)	$15	$25
Follow-up Office Visits (Advice and/or Examinations)	$15	$25

5. **Bereavement Care** - Family Health Hawaii understands the painful feelings surrounded by the death of a loved one. Some people reach a resolution on their own and with social and family support. Others benefit from the support of a grief counselor. Family Health Hawaii offers 10 Bereavement counseling visits per covered member per calendar year. Family Health Hawaii pays 80% of the EME* (Benefit maximum applies).

6. **Respite Care** - Is the provision of short-term, temporary relief for the Family Health Hawaii member who is terminally ill or the Family Health Hawaii member who is providing the care to an immediate family member who is terminally ill. Family Health Hawaii will cover 15 days / 20 visits per Calendar Year to the member as follows:

Inpatient Respite Care	A maximum Benefit of 15 days per covered member per calendar year. Family Health Hawaii pays 80% of the EME* (Benefit maximum applies)
Outpatient Respite Care	A maximum Benefit of 20 Visits per covered member per calendar year: Family Health Hawaii pays 80% of the EME* (Benefit maximum applies)

7. **Cardiac and Pulmonary Rehabilitation** - Any combination of doctor monitored Cardiac and/or Pulmonary Rehabilitation ambulatory care visits rendered to a member who have had an adverse cardiac event or who have a chronic debilitating pulmonary disease, such as Chronic Obstructive Pulmonary, and/or Cardio-Pulmonary Rehabilitation Services and are covered under this Integrated Care Rider and Guide to Benefits. This benefit has a maximum of 30 visits per member per calendar year. Family Health Hawaii pays 80% of the EME* (Benefit Maximum applies).

8. **TMJ (Temporomandibular) Treatment** - Diagnosing TMJ disorders is often complex and therefore should be conducted by an oral and maxillofacial surgeon – experts in the field of the mouth, teeth and jaw. An accurate diagnosis of TMJ is very important before starting a treatment plan. Coverage for TMJ benefits must meet Family Health Hawaii's clinical criteria and is required to have a Prior Authorization review. If medical necessity has been met, Family Health Hawaii will pay up to $1,500 per member per Calendar Year.

   Please note: When services are recommended or provided by a Participating Provider, that provider is responsible for obtaining any required Prior Authorization on the member's behalf. If you are using a Non-Participating Provider it is the member's responsibility to make sure that the Non-Participating Provider has filed the Prior Authorization on your behalf. It is very important that the member works closely with their provider to ensure that the Prior Authorizations have been met. If the member receives services from a non-participating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely.

   Any additional services or treatments not listed above are not covered under this rider and will be excluded from coverage under the Integrated Care Rider. For a list of benefits that fall under your medical plan, please see the Summary of Benefits and Guide to Benefits booklet for more details on services that are covered and/or excluded under your medical plan. If you have questions on coverage please contact Family Health Hawaii at (808) 457-3277 or toll free at (855) 206-3277. You may also visit us on the web at **www.familyhealthhawaii.com** for more information.

FamilyHealth
HAWAII

HIintegrative Care SB

Schedule of Benefits: Small Business Health Insurance Plan

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.

HIintegrative Care SB

This supplemental rider covers certain integrated care benefits. When the member elects to access these integrated care benefits, they may be obtained In-Network or Out-of-Network. Family Health Hawaii encourages our members to use a participating Provider to help ensure a lower Out-of-Pocket cost to the member.

You pay the specialty care visit co-payment or coinsurance listed below in the Summary of Benefits for services received under this integrated care services rider. These co-payments or coinsurance are not subject to your annual deductible and do not accumulate towards your out-of-pocket maximum. There is a Calendar Year Benefit Maximum for care obtained under the Integrated Care Rider. After you reach the benefit maximum, we will not cover any more services under this rider for the rest of the calendar year. It is the member's responsibility to pay the full amount of any charges incurred for services received that exceeds the benefit maximum per calendar year. The Family Health Hawaii Integrated Care Rider is a geographically limited plan, which means that Coverage is limited to integrated care services obtained in Hawai'i.

This Supplemental Rider has been sold to your employer's company by Family Health Hawaii. These Benefits will end if the member leaves the Group through which this Rider is issued or the member no longer meets the participation requirements which makes the member eligible for the Benefits under this Rider.

All Coverage provided under this Supplemental Rider is subject to the restriction of the Eligible Charge maximum for each Care Service. The Eligible Medical Expense (EME*) = the lesser of the Contracted Fee or the Billed Amount (If there is No Contracted Fee, then 90% of Medicare is used to determine that component of the EME).

Integrative Care Rider Services

- Chiropractic
- Acupuncture
- Massage Therapy
- Naturopathic
- Bereavement
- Respite
- TMJ (Temporomandibular) Treatment

Coverage Under the Integrative Care Rider

Chiropractic, Acupuncture, Naturopathic, and Massage Therapy have a Calendar year Benefit Maximum of **$650.00** paid by Family Health Hawaii for any and all Chiropractic, Acupuncture, Naturopathic and Massage Therapy Care Services Covered under this section of the Rider.

1. **Chiropractic** - We cover care that is determined to be medically necessary. Coverage is provided for Care Services rendered by a Chiropractor, which may include benefits in any one, up to all, of the following four categories:

Covered Services	In-Network	Out-of-Network
Spinal Manipulation	$15	$25
Physical Therapy	$10	$15
Office Visit (Examination)	$10	$15
X-Rays (First Set, additional sets are not covered)	50% of EC	Not Covered

2. **Acupuncture** - Coverage provided for the following Acupuncture services. Each is subject to a Co-Pay per visit.

Covered Services	In-Network	Out-of-Network
Evaluation and Management	$15	$25
Acupuncture	$15	$25
Electro-Acupuncture	$15	$25

3. **Massage Therapy** - Covered services involves the manipulation of soft tissue structures of the body to help pain, muscle discomfort and stress by helping promote health and wellness. We cover up to 6 visits per calendar year. A prescription is required from your treating Physician or Chiropractor. Covered services include:

Covered Services	In-Network	Out-of-Network
Evaluation and Management	20% Co-Pay per visit	Not Covered

HIintegrative Care SB

4. **Naturopathic** - Is a holistic approach to the diagnosis, treatment, and prevention of illness. The Coverage is subject to a Co-Pay per visit. Dispensed items are excluded from Coverage. Also excluded are Laboratory Tests and other Diagnostic Studies, whether performed in the office or sent out by the Naturopath. Covered services include:

Covered Services	In-Network	Out-of-Network
Initial Office Visits (Examinations)	$15	$25
Follow-up Office Visits (Advice and/or Examinations)	$15	$25

5. **Bereavement Care** - Family Health Hawaii understands the painful feelings surrounded by the death of a loved one. Some people reach a resolution on their own and with social and family support. Others benefit from the support of a grief counselor. Family Health Hawaii offers 10 Bereavement counseling visits per covered member per calendar year. Family Health Hawaii pays 80% of the EME* (Benefit maximum applies).

6. **Respite Care** - Is the provision of short-term, temporary relief for the Family Health Hawaii member who is terminally ill or the Family Health Hawaii member who is providing the care to an immediate family member who is terminally ill. Family Health Hawaii will cover 15 days / 20 visits per Calendar Year to the member as follows:

Inpatient Respite Care	A maximum Benefit of 15 days per covered member per calendar year. Family Health Hawaii pays 80% of the EME* (Benefit maximum applies)
Outpatient Respite Care	A maximum Benefit of 20 Visits per covered member per calendar year: Family Health Hawaii pays 80% of the EME* (Benefit maximum applies)

7. **TMJ (Temporomandibular) Treatment** - Diagnosing TMJ disorders is often complex and therefore should be conducted by an oral and maxillofacial surgeon — experts in the field of the mouth, teeth and jaw. An accurate diagnosis of TMJ is very important before starting a treatment plan. Coverage for TMJ benefits must meet Family Health Hawaii's clinical criteria and is required to have a Prior Authorization review. If medical necessity has been met, Family Health Hawaii will pay up to $1,500 per member per Calendar Year.

   Please note: When services are recommended or provided by a Participating Provider, that provider is responsible for obtaining any required Prior Authorization on the member's behalf. If you are using a Non-Participating Provider it is the member's responsibility to make sure that the Non-Participating Provider has filed the Prior Authorization on your behalf. It is very important that the member works closely with their provider to ensure that the Prior Authorizations have been met. If the member receives services from a non-participating provider and approval for certain services is not obtained, benefits may be denied. In some cases, benefits are denied entirely.

   Any additional services or treatments not listed above are not covered under this rider and will be excluded from coverage under the Integrated Care Rider. For a list of benefits that fall under your medical plan, please see the Summary of Benefits and Guide to Benefits booklet for more details on services that are covered and/or excluded under your medical plan. If you have questions on coverage please contact Family Health Hawaii at (808) 457-3277 or toll free at (855) 206-3277. You may also visit us on the web at **www.familyhealthhawaii.com** for more information.

FamilyHealth
HAWAII

HIpreferred Plan

Schedule of Benefits: Health Insurance Plan (Large Group)

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.

FamilyHealth HAWAII

Schedule of Benefits

HIpreferred Medical Plan (Large Group)

HIpreferred Plan – Medical Benefits

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). The Out-of-Pocket Maximum is the maximum deductible, coinsurance, and copayment amounts you pay in a calendar year. Once you meet the Out-of-Pocket Maximum, you are no longer responsible for deductible, coinsurance, or copayment amounts unless otherwise noted.

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
Physician Services		
Physician Visits: Office, Hospital, Skilled Nursing Facility, and Home	$12 Copay per visit	30%
Consultations	$12 Copay per visit	30%
Physical Exams	$10 Copay	30%
Emergency Services		
Emergency Room / Physician	10%	10%
Outpatient Emergency Room	10%	10%
Urgent Care Center Visit	$15 Copay	30%
Preventive Care Services		
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%
Preventive Services – U.S. Preventive Services Task Force (USPSTF) Recommended A & B – not listed in this section	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	No Copay	30%
Prostate Specific Antigen (PSA) Screening (Age 50 and older) – Limited to 1 per CY	No Copay	30%
Sigmoidoscopy Screening	No Copay	30%
Immunizations (Standard)	No Copay	30%
Maternity Services		
Maternity Care	10%	30%
Newborn Circumcision	10%	30%
Newborn Nursery	No Copay	30%
Breast Pumps	No Copay	Not Covered
Interrupted Pregnancy	10%	30%

HIpreferred℠ Plan – Medical Benefits

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
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%
Tuberculin Test Screening – Limited to 1 per CY	10%	30%
Surgical Services		
(Certain Surgical Services many Require Prior Authorization)		
Anesthesia	10%	30%*
Assistant Surgeon Services	10%	30%*
Cutting Surgery – Inpatient	10%	30%*
Cutting Surgery - Outpatient	10%	30%*
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 and Lung, Kidney, Liver, Lung, Pancreas, Simultaneous Kidney/Pancreas, Small Bowel and Multivisceral, and Stem-Cell (Including Bone Marrow)	No Copay	Not Covered

CY = Calendar Year * = Calendar Year (CY) Deductible applies

HIpreferred℠ Plan – Medical Benefits

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
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%
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%*
Tele-Health Services – 15 minute Session Limitation	$12 Copay per Session	Not Covered

CY = Calendar Year * = Calendar Year (CY) Deductible applies

HIpreferred℠ Plan – Medical Benefits

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 Contraceptives (Generic)	No Copay	20%
Oral Contraceptives (Preferred)	20%	20%
Oral Contraceptives (Other Brand Name)	30%	30%
Contraceptive – Other Method (Generic)	No Copay	20%
Contraceptive – Other Method (Preferred)	20%	20%
Contraceptive – Other Method (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%
U.S. Preventive Services Task Force (USPSTF) Recommended Preventive Medication – Dispensed by Pharmacy		
USPSTF Recommended Preventive Medication	No Copay	No Copay
Chemotherapy Drugs – Dispensed by Pharmacy		
Chemotherapy - Oral	No Copay	No Copay
Mail Order Chemotherapy – Oral	No Copay	Not Covered

FamilyHealth
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HIselect Plan

Schedule of Benefits: Health Insurance Plan (Large Group)

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.

FamilyHealth HAWAII

Schedule of Benefits

HIselect Medical Plan (Large Group)

HIselect- Medical Benefits

Dependent Age	Up to Age 26
Calendar Year (CY) Deductible*	No Deductible
Out-of-Pocket Maximum	$2,000 Per Person / Maximum $6,000 Per Family

Copayment Is (Percentage copayments are based on Eligible Medical Expenses). The Out-of-Pocket Maximum is the maximum deductible, coinsurance, and copayment amounts you pay in a calendar year. Once you meet the Out-of-Pocket Maximum, you are no longer responsible for deductible, coinsurance, or copayment amounts unless otherwise noted.

Physician Services		
Summary of Benefits	**Participating**	**Non-Participating based on Eligible Medical Expense**
Physician Visits: Office, Hospital, Skilled Nursing Facility, and Home	$14 Copay per visit	$14 Copay Per visit
Consultations	$14 Copay per visit	$14 Copay Per visit
Physical Exams	$10 Copay	$10 Copay
Emergency Services		
Emergency Room / Physician	20%	20%
Outpatient Emergency Room	20%	20%
Urgent Care Center Visit	$15 Copay per visit	$15 Copay per visit
Preventive Care Services		
Well Child Care Physician Office Visits (Newborn to 21 years old)	No Copay	No Copay
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	No Copay
Well Woman Exam – Limited to 1 per CY	No Copay	No Copay
Preventive Services – U.S. Preventive Services Task Force (USPSTF) Recommended A & B – not listed in this section	No Copay	No Copay
Cervical Cancer Screening (Pap Smear) – Limited to 1 per CY	No Copay	No Copay
Chlamydia Screening	No Copay	No Copay
Colonoscopy Screening	No Copay	No Copay
Fecal Occult Blood Test (FOBT) Screening	No Copay	No Copay
Mammography for Breast Cancer Screening Limited to 1 baseline for ages 35 - 39 and 1 per CY for ages 40 and older	No Copay	No Copay
Osteoporosis Screening (Peripheral DexaScan or Ultrasound of the heel) Limited to 1 per CY	No Copay	20%
Prostate Specific Antigen (PSA) Screening (Age 50 and older) – Limited to 1 per CY	No Copay	No Copay
Sigmoidoscopy Screening	No Copay	No Copay
Immunizations (Standard)	No Copay	No Copay
Maternity Services		
Maternity Care	10%	10%
Newborn Circumcision	10%	10%
Newborn Nursery	No Copay	No Copay
Breast Pumps	No Copay	No Copay
Interrupted Pregnancy	10%	10%

HIselect - Medical Benefits

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
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	20%	20%
Diagnostic Testing, Laboratory, and Radiology Services		
Allergy Testing	20%	20%
Allergy Treatment	20%	20%
Diagnostic Testing – Inpatient	20%	20%
Diagnostic Testing – Outpatient	20%	20%
Laboratory and Pathology – Inpatient	20%	20%
Laboratory and Pathology – Outpatient	No Copay	No Copay
Radiology - Inpatient (Authorization required for PET Scans, CTCA and Dexa Scans)	20%	20%
Radiology - Outpatient (Authorization required for PET Scans, CTCA and Dexa Scans)	20%	20%
Tuberculin Test Screening – Limited to 1 per CY	20%	20%
Surgical Services		
(Certain Surgical Services many Require Prior Authorization)		
Anesthesia	20%	20%
Assistant Surgeon Services	20%	20%
Cutting Surgery – Inpatient	20%	20%
Cutting Surgery - Outpatient	20%	20%
Non-Cutting Surgery – Inpatient	20%	20%
Non-Cutting Surgery – Outpatient	20%	20%
Reconstructive Surgery (Authorization Required)	20%	20%
Second Opinions (Authorization required for opinions rendered by out-of-state providers)	No Copay	No Copay
Surgical Supplies	20%	20%
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	No Copay
Organ Donor Services	20%	20%
Transplants Coverage limited to Corneal, Heart and Lung, Kidney, Liver, Lung, Pancreas, Simultaneous Kidney/Pancreas, Small Bowel and Multivisceral, and Stem-Cell (Including Bone Marrow)	No Copay	No Copay

FamilyHealth HAWAII

Schedule of Benefits

HIselect Medical Plan (Large Group)

HIselect - Medical Benefits

Summary of Benefits	Participating	Non-Participating based on Eligible Medical Expense
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	20%	20%
Hospice Services	No Copay	No Copay
Hospital Ancillary Services	20%	20%
Hospital Operating Room	20%	20%
Hospital Room and Board (Authorization Required)	20%	20%
Intensive Care Unit/Coronary Care Unit (Authorization Required)	20%	20%
Intermediate Care Unit (Authorization Required)	20%	20%
Isolation Care Unit (Authorization Required)	20%	20%
Outpatient Facility (Authorization Required)	20%	20%
Skilled Nursing Facility (Authorization Required) Limited to 120 days per CY	20%	20%
Behavioral Health – Mental Health and Substance Abuse		
Hospital and Facility Services – Inpatient (Authorization Required)	20%	20%
Hospital and Facility Services – Outpatient	20%	20%
Physician Services – Inpatient	No Copay	No Copay
Physician Services - Outpatient	$14 Copay per visit	$14 Copay per visit
Psychological Testing – Inpatient	20%	20%
Psychological Testing – Outpatient	20%	20%
Ancillary Services		
Ambulance (Air)	20%	20%
Ambulance (Ground)	20%	20%
Blood and Blood Products	20%	20%
Chemotherapy – Infusion / Injections	20%	20%
Dialysis and Supplies	20%	20%
Durable Medical Equipment and Supplies (Authorization Required)	20%	20%
Durable Medical Equipment – Repair	20%	20%
Genetic Testing and Counseling (Authorization Required)	20%	20%
Growth Hormone Therapy (Authorization Required)	20%	20%
Hearing Evaluation	$14 Copay per visit	$14 Copay per visit
Hearing and Vision Appliances	20%	20%
Home Health Care – Limited to 150 visits per CY (Authorization Required)	20%	20%
Home IV Therapy	20%	20%
Inhalation Therapy	20%	20%
Outpatient Injections	20%	20%
In Vitro Fertilization (Authorization Required) Limited to one time, 1 cycle per lifetime on plan	20%	20%
Medical Foods (Does not apply to the Out-of-Pocket Maximum)	20%	20%
Orthotics and External Prosthetics and Supplies	20%	20%
Orthotics and Prosthetics – Repair and Replacement	20%	20%
Physical and Occupational Therapy – Inpatient	20%	20%
Physical and Occupational Therapy – Outpatient	20%	20%
Radiation Therapy – Inpatient	20%	20%
Radiation Therapy – Outpatient	20%	20%
Speech Therapy – Inpatient	20%	20%
Speech Therapy – Outpatient	20%	20%
Tempormandibular Joint and Malocclusion of Teeth and Jaw	20%	20%
Tele-Health Services – 15 minute Session Limitation	$14 Copay per Session	Not Covered

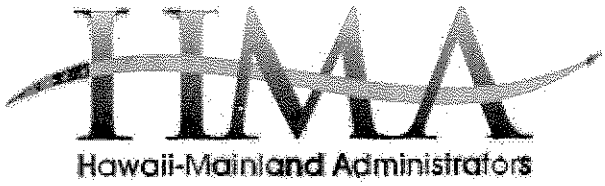
HIselect - Medical Benefits

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	No Copay
Oral Contraceptives (Generic)	No Copay	No Copay
Oral Contraceptives (Preferred)	20%	20%
Oral Contraceptives (Other Brand Name)	30%	30%
Contraceptive – Other Method (Generic)	No Copay	No Copay
Contraceptive – Other Method (Preferred)	20%	20%
Contraceptive – Other Method (Other Brand Name)	30%	30%
Specific Benefits for Diabetes – Dispensed by Pharmacy		
Diabetic Supplies (Generic)	No Copay	No Copay
Diabetic Supplies (Preferred)	20%	20%
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%
U.S. Preventive Services Task Force (USPSTF) Recommended Preventive Medication – Dispensed by Pharmacy		
USPSTF Recommended Preventive Medication	No Copay	No Copay
Chemotherapy Drugs – Dispensed by Pharmacy		
Chemotherapy - Oral	No Copay	No Copay
Mail Order Chemotherapy – Oral	No Copay	Not Covered

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST



HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	Non-Participating Provider
Annual Deductible (by Plan Year)	$100 per person for Other Medical Benefits $300 per family (3 or more) for Other Medical Benefits	
Annual Co-payment (by Plan Year)	$2,500.00 per person $7,500.00 per family (3 or more)	$2,500.00 per person $7,500.00 per family (3 or more)
Annual Maximum	None (eff. 09/01/14)	None (eff. 09/01/14)
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF, visits (Hosp inpt visits limited to 1 per day)	90% of E.C.	80% of E.C.*
Well-Baby Care 0-2 years (8 visits)	90% of E.C.	80% of E.C.*
Well-Baby Care (1 visit each during ages 2-5)	90% of E.C.	80% of E.C.*
Limited to the following tests thru age five: two tuberculin tests, two blood tests (hemoglobin & hematocrit) and one urinalysis		
Well-Baby Immunizations	90% of E.C.	80% of E.C.*
Immunizations	80% of E.C.	80% of E.C.*
(Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus, chicken pox, and streptococcus pneumonia).		
HPV is covered for females (eff 05/01/07) and males (eff 06/01/14) when the first dose is administered to an 11-12 year old beneficiary with the second or third dose administered prior to 13 years old. For beneficiaries ages 13-18 years of age, the HPV vaccine is covered at 50% E.C. for par and non-par providers when the first dose is administered to a 13-18 year old beneficiary with the second and third dose administered prior to 19 years of age.		
Effective 9/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administered by 32 weeks of age.		
HOSPITAL SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C. (365 days maximum per Calendar Year)	80% of E.C.*
Intensive Care Unit, Coronary Care Unit	100% of E.C.	80% of E.C.*
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	80% of E.C.*
Ancillary Services	90% of E.C.	80% of E.C.*
Life Bed (effective 01/01/08)	Covered at an E.C. of $18.00/day	Covered at an E.C. of $18.00/day *
Laboratory,Diagnostic Tests, and other X-ray Films	90% of E.C.	80% of E.C.*
X-ray Films (X-ray films for injuries (within 48 hours), Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	80% of E.C.	80% of E.C.*
Emergency Room	100% of E.C. **Not covered if not a true emergency**	80% of E.C.*
Outpatient Surgical Center	100% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays and life bed	
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	90% of E.C.	80% of E.C.*
Anesthesiologist	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Reconstructive surgery	

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

(Rev. 07/2014)

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	Non-Participating Provider
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
X-Ray Films (X-ray for injuries (within 48 hours), Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Laboratory, Diagnostic Tests, other X-ray Films, and Radiotherapy for non-malignancy	80% of E.C.	80% of E.C.*
Well-Baby Care Laboratory Tests	80% of E.C.	80% of E.C.*
Mammography (Limited to one baseline mammogram ages 35-39 and one mammogram every 12 months for ages 40 and above)	80% of E.C.	80% of E.C.*
Routine Pap Smear (Limited to one (1) per Calendar Year)	80% of E.C.	80% of E.C.*
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	80% of E.C.	80% of E.C.*
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	80% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Imaging Scans (MRI,MRA,PET) Gamma Knife/X Knife Greater than two (2) OB ultrasounds	
MATERNITY SERVICES		
Physicians Services	90% of E.C.	80% of E.C.*
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	80% of E.C.*
Birthing Center Services	100% of E.C.	80% of E.C.*
In Vitro Fertilization (Limited to one (1) procedure per lifetime)	90% of E.C. Physicians Services	80% of E.C.*
	80% of E.C. Labs & X-rays	80% of E.C.*
Member must have been covered under the Plan for 12 consecutive months immediately preceding the in vitro fertilization procedure.		
PRIOR AUTHORIZATION REQUIRED:	In-vitro fertilization Infertility studies and treatments/procedures	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	80% of E.C.	80% of E.C.*
Outpatient Physician Services	90% of E.C.	80% of E.C.*
Psychological Testing	80% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Mental Health Services - require a treatment plan Substance Abuse Programs - require a treatment plan	
SKILLED NURSING FACILITY	(Up to 120 days in any one calendar year) Room & board based on semi private room rate	
Inpatient Services	90% of E.C.	80% of E.C.*
Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits		
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	Non-Participating Provider
HOSPICE CARE SERVICES	(Up to 150 days of hospice services for a terminal illness)	
	100% of E.C.	Not Covered
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
HOME HEALTH CARE	(Up to 150 home health care visits per Calendar Year)	
	100% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	
AMBULANCE SERVICES		
Automobile	90% of E.C.	80% of E.C.*
Air (Limited to inter-island transportation within the State of Hawaii)	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
OTHER BENEFITS		
Allergy Testing Limited to one series of tests per calendar year	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Appliances & Equipment Includes hearing aids - one device per ear every five (5) years	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Evaluations for Hearing Aids	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Chemotherapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Dialysis & Supplies	80% of E.C. after annual deductible (eff. 06/01/13 - E.C. for dialysis at 150% of Medicare eligible)	80% of E.C. after annual deductible *
Organ Donor Services	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Outpatient Injections	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Physical & Occupational Therapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Speech Therapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Weight loss services Physical Therapy Speech Therapy Occupational Therapy Durable Medical Equipment (DME) Infusion Therapy Human Growth Hormone Dialysis Chemo/Radiation Therapy Orthotics and Prosthetics	

Non-Emergency Inter Island Travel Benefits (eff. 2/1/14)

Air Travel: up to $200.00, or the actual cost of the fare, whichever is less.
Taxi: up to $50.00, or the actual cost of the fare, whichever is less.
Ferry: up to $50.00, or the actual cost of the fare, whichever is less, for Beneficiaries residing on the island of Lanai
Lodging: up to $100.00 per night for up to two nights, when the Beneficiary is unable to receive the medically necessary services without an overnight stay
(Plan will reimburse qualified travel expenses for one accompanying parent/guardian up to the benefit limitation for a minor child under 18 yrs of age)

PRIOR AUTHORIZATION REQUIRED: Non-Emergency Inter-Island Travel Benefit

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND
(OTS Retirees Age 62 and Over)

Benefits	Comprehensive Medical Plan	
	Participating Provider	Non-Participating Provider
Annual Deductible (by Plan Year)	$100.00 for Other Medical Benefits	
Annual Co-payment (by Plan Year)	$2,500.00 per person $7,500.00 per family (3 or more)	$2,500.00 per person $7,500.00 per family (3 or more)
Annual Maximum	$750,000 per person $1,250,000 per person (eff. 09/01/12)	$750,000 per person $1,250,000 per person (eff. 09/01/12)
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF, visits (Hosp inpt visits limited to 1 per day)	90% of E.C.	80% of E.C.*
Well-Baby Care 0-12 mos. (6 visits) Well-Baby Care 1-2 years (2 visits) Well-Baby Care (1 visit each during ages 2-5) Limited to the following tests thru age five: two tuberculin tests, two blood tests (hemoglobin & hematocrit) and one urinalysis	90% of E.C.	80% of E.C.*
Well-Baby Immunizations	90% of E.C.	80% of E.C.*
Immunizations Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken box, and streptococcus pneumonia.	80% of E.C.	80% of E.C.*
Effective 5/1/07: **HPV** is covered when the first dose is administered to an 11-12 year old female with the second or third dose administered prior to 13 years old. For females ages 13-18 years of age, the HPV vaccine is covered at 50% E.C. for par and non-par providers when the first dose is administered to a 13-18 year old with the second and third dose administered prior to 19 years of age.		
Effective 9/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old require prior auth **Rotavirus** vaccine covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administrated by 32 weeks of age		
HOSPITAL SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C. (365 days maximum per Calendar Year)	80% of E.C.*
Intensive Care Unit, Coronary Care Unit	100% of E.C.	80% of E.C.*
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	80% of E.C.*
Ancillary Services	90% of E.C.	80% of E.C.*
Life Bed (Effective 01/01/08)	Covered at an E.C. of $18.00/day	Covered at an E.C. of $18.00/day
Laboratory, Diagnostic Tests, Other X-ray Films	90% of E.C.	80% of E.C.*
X-ray Films & Radiotherapy X-ray films for injuries (within 48 hours), Radiotherapy for malignancy	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	80% of E.C.	80% of E.C.*
Emergency Room	100% of E.C. (Must be true emergency)	80% of E.C.* (Must be true emergency)
	Not covered if not a true emergency	
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays	
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	90% of E.C.	80% of E.C.*
Anesthesiologist	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Reconstructive surgery	

*Member owes any differences between the actual charges and eligible charges (E.C.)

(Revised 08/08/12)

Benefits	Comprehensive Medical Plan	
	Participating Provider	**Non-Participating Provider**
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory, Diagnostic Tests, Other X-ray Films	80% of E.C.	80% of E.C.*
X-Ray Films and Radiotherapy (For injuries (within 48 hours), Radiotherapy for malignancy)	100% of E.C.	80% of E.C.*
Radiotherapy for non-malignancy	80% of E.C.	80% of E.C.*
Well-Baby Care Laboratory Tests	80% of E.C.	80% of E.C.*
Mammography (Limited to one (1) baseline mammo age 35-39 and one(1) mammo every 12 months for ages 40 and above)	80% of E.C.	80% of E.C.*
Routine Pap Smear (Limited to one (1) Calendar Year)	80% of E.C.	80% of E.C.*
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	80% of E.C.	80% of E.C.*
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	80% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Imaging Scans (MRI,MRA,PET) Gamma Knife/X Knife Greater than two (2) OB ultrasounds	
MATERNITY SERVICES		
Physicians Services	90% of E.C.	80% of E.C.*
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	80% of E.C.*
Birthing Center Services	100% of E.C.	80% of E.C.*
In Vitro Fertilization (Limited to one (1) procedure per lifetime)	90% of E.C. Physicians Services	80% of E.C.*
	80% of E.C. Labs & X-rays	80% of E.C.*
Member must have been covered under the Plan for 12 consecutive months immediately preceding the in vitro fertilization procedure.		
PRIOR AUTHORIZATION REQUIRED:	In-vitro fertilization	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	80% of E.C.	80% of E.C.*
Outpatient Physician Services	90% of E.C.	80% of E.C.*
Psychological Testing	80% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Mental Health Services - require a treatment plan Substance Abuse Programs - require a treatment plan	

*Member owes any differences between the actual charges and eligible charges (E.C.)

HAWAII TEAMSTERS HEALTH AND WELFARE TRUST FUND
(OTS Retirees Age 62 and Over)

Benefits	Comprehensive Medical Plan	
	Participating Provider	**Non-Participating Provider**
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits	90% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	
HOSPICE CARE SERVICES	(Up to 150 days of hospice services for a terminal illness)	
	100% of E.C.	Not Covered
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
HOME HEALTH CARE	(Up to 150 home health care visits per Calendar Year)	
	100% of E.C.	80% of E.C.*
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	
AMBULANCE SERVICES		
Automobile	90% of E.C.	80% of E.C.*
Air (Limited to inter-island transportation within the State of Hawaii)	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Appliances & Equipment (DME) Includes hearing aids - one device per ear every five (5) years	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Evaluations for Hearing Aids	80% of E.C. after annual deductible	80% of E.C*. after annual deductible
Chemotherapy	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Dialysis & Supplies	80% of E.C. after annual deductible (eff. 06/01/13 - E.C. for dialysis at 150% of Medicare eligible)	80% of E.C.* after annual deductible
Organ Donor Services	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Outpatient Injections	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Physical & Occupational Therapy	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
Speech Therapy	80% of E.C. after annual deductible	80% of E.C.* after annual deductible
PRIOR AUTHORIZATION REQUIRED:	Infertility studies and treatment/procedures Weight loss services Physical Therapy Speech Therapy Occupational Therapy Durable Medical Equipment (DME) Infusion Therapy Human Growth Hormone Dialysis Chemo/Radiation Therapy Orthotics and Prosthetics	

Non-Emergency Off Island Travel Benefits (eff. 1/1/12)

Air Travel: up to $200.00 or the actual cost of the fare, whichever is less
Taxi: up to $50.00 or the actual cost of the fare, whichever is less, on the island of Oahu
Ferry: up to $50.00 or the actual cost of the fare, whichever is less, for Beneficiaries residing on the island of Lanai traveling to Maui
(Plan will reimburse qualified travel expenses for one accompanying parent/guardian up to the benefit limitation for a minor child under 18 yrs of age
***PRIOR AUTHORIZATION REQUIRED**

*Member owes any differences between the actual charges and eligible charges (E.C.)

(Revised 08/08/12)

ILWU LOCAL 142 HOTEL

ILWU LOCAL 142 HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	**Non Participating Provider**
Annual Deductible	No Deductible	$100 per person $300 per family
Annual Co-payment	$2,500.00 per person $7,500.00 per family (3 or more)	$2,500.00 per person $7,500.00 per family (3 or more)
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF visits (Hosp inpt visits limited to one (1) per day)	90% of E.C.	75% of E.C. after annual deductible *
Well-Child Care 0-2 years (8 visits)	100% of E.C.	75% of E.C. after annual deductible *
Well-Child (1 visit each during ages 2-5 years)	100% of E.C.	75% of E.C. after annual deductible *
(Limited to two (2) tuberculin tests, two (2) blood tests (hemoglobin or hemtocrit), and one (1) urinalysis)		
Immunizations	90% of E.C. (100% of E.C. for well-child care)	75% of E.C. after annual deductible * (100% of E.C. for well-child care) after annual deductible *
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumoniae.		
HPV is covered for females (eff 05/01/07) and males (eff 12/05/12) when the first dose is administered to an 11-12 year old with the second or third dose administered prior to 13 years of age. During ages 13-18, the HPV vaccine is covered at 50% E.C. for par and non-par providers when the first dose is administered to a 13-18 year old with the second and third dose administered prior to 19 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administered by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C. (365 days maximum per Calendar Year)	75% of E.C. after annual deductible *
Intensive Care Unit, Coronary Care Unit	100% of E.C.	75% of E.C. after annual deductible *
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	75% of E.C. after annual deductible *
Life Bed (Effective 01/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day after annual deductible *
Ancillary Services	90% of E.C.	75% of E.C. after annual deductible *
Emergency Room	90% of E.C. **Not covered if not a true emergency**	75% of E.C. after annual deductible *
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	90% of E.C.	75% of E.C. after annual deductible *
Radiotherapy for non-malignancy	90% of E.C.	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	All inpatient admissions including acute, skilled and observation stays and Life Bed	
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	90% of E.C.	75% of E.C. after annual deductible *
Anesthesiologist	90% of E.C.	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Reconstructive surgery	
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray films ordered within 48 hours following an injury, Radiotherapy for malignancy)	90% of E.C.	75% of E.C. after annual deductible *
Radiotherapy for non-malignancy	90% of E.C.	75% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	Non Participating Provider
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	90% of E.C.	75% of E.C. after annual deductible *
Mammography (Limited to one (1) baseline mammogram age 35-39 and one mammogram every calendar year for ages 40 and above)	100% of E.C.	75% of E.C. after annual deductible *
Routine Pap Smear (Limited to one (1) per Calendar Year)	100% of E.C.	75% of E.C. after annual deductible *
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	100% of E.C.	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Imaging Scans (MRI,MRA,PET) Gamma Knife/X Knife Greater than two (2) OB ultrasounds	
MATERNITY SERVICES		
Physicians Services	90% of E.C.	75% of E.C. after annual deductible *
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	75% of E.C. after annual deductible *
Birthing Center Services	100% of E.C.	75% of E.C. after annual deductible *
In Vitro Fertilization (Limited to one procedure per lifetime)	90% of E.C. Physicians Services	75% of E.C. after annual deductible *
	90% of E.C. Labs & X-rays	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Infertility studies and treatment/procedures In-vitro fertlization	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	90% of E.C.	75% of E.C. after annual deductible *
Outpatient Physician Services	90% of E.C.	75% of E.C. after annual deductible *
Psychological Testing	90% of E.C.	75% of E.C. after annual deductible *
SKILLED NURSING FACILITY	(Up to 150 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.	100% of E.C.	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Skilled Nursing Facility	
HOSPICE CARE SERVICES	100% of E.C.	Not Covered
PRIOR AUTHORIZATION REQUIRED:	Hospice Care Services	
HOME HEALTH CARE	(Up to 150 home health care visits per calendar year)	
	100% of E.C.	75% of E.C. after annual deductible *
PRIOR AUTHORIZATION REQUIRED:	Home Health Care	

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

ILWU LOCAL 142 HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Provider	Non Participating Provider
AMBULANCE SERVICES		
Not covered if not a true emergency		
Automobile	90% of E.C.	75% of E.C. after annual deductible *
Air	80% of E.C.	75% of E.C. after annual deductible *
For transportation within the State of HI & United States of America when facilities within the State of HI are not equipped to furnish treatment.		
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	80% of E.C.	75% of E.C. after annual deductible *
Appliances & Equipment (DME) Includes hearing aids - one (1) device per ear every five (5) years	80% of E.C.	75% of E.C. after annual deductible *
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C.	75% of E.C. after annual deductible *
Evaluations for Hearing Aids	80% of E.C.	75% of E.C. after annual deductible *
Chemotherapy	80% of E.C.	75% of E.C. after annual deductible *
Dialysis & Supplies	80% of E.C.	75% of E.C. after annual deductible *
	(eff. 06/01/13 - E.C. for dialysis at 150% of Medicare eligible)	
Organ Donor Services	80% of E.C.	75% of E.C. after annual deductible *
Outpatient Injections		
Self-Administered	90% of E.C.	75% of E.C. after annual deductible *
Non Self-Administered	80% of E.C.	75% of E.C. after annual deductible *
Physical & Occupational Therapy	80% of E.C.	75% of E.C. after annual deductible *
Speech Therapy	80% of E.C.	75% of E.C. after annual deductible *
IUD for contraceptive purposes	50% of E.C.	50% of E.C. after annual deductible *
	Limited to one IUD every 5 years	
PRIOR AUTHORIZATION REQUIRED:	Weight loss services Physical Therapy Speech Therapy Occupational Therapy Durable Medical Equipment (DME) Infusion Therapy Human Growth Hormone Dialysis Chemo/Radiation Therapy Orthotics and Prosthetics	

Non-Emergency Inter Island Travel for all Beneficiaries who do not reside on the Island of Oahu (eff. 9/1/12)

Air Travel: Up to $200 or the actual cost of the fare, whichever is less
Ferry: Up to $50 or the actual cost of the fare, whichever is less, for Beneficiaries residing on the Island of Lanai
Taxi: Reimbursement to and from the airport of up to $50, or the actual cost of the fare, whichever is less, on the Island of Oahu
(Plan will reimburse qualified travel expenses for one accompanying parent/guardian up to the benefit limitation for a minor child under 18yrs of age)

PRIOR AUTHORIZATION REQUIRED: Non-Emergency Inter Island Travel

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

ILWU LOCAL 142 HEALTH AND WELFARE TRUST FUND
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan	
	Participating Providers	Non Participating Provider
PHYSICAL EXAMS	One per calendar year	
For ages 6-12: (For preschool examination form 414)	100% of E.C.	100% of E.C. after annual deductible *
For ages 13-21:	100% of E.C.	100% of E.C. after annual deductible *
For ages 22-39: Includes: Complete history & physical exam Audiogram-optional Urinalysis Blood count Chest x-ray-optional (not more than once every 2 years)	100% of E.C. up to $115	100% of E.C. up to $115 after annual deductible *
For ages 40 and older: Includes: Complete history & physical exam Audiogram-optional Urinalysis Blood count Chest x-ray-optional (not more than once every 2 years) Biochemistry chemistry Electrocardiogram (EKG 12 lead)	100% of E.C. up to $175	100% of E.C. up to $175 after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

TIMES SUPERMARKET

HMA

Hawaii-Mainland Administrators

PPO Summary of Benefits (Effective January 1, 2015)

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
Annual Deductible	$100 Per Person/$300 Per Family	$100 Per Person
	For Other Services*	$300 Per Family
Annual Co-payment Maximum	$2,500 Per Person, Maximum $7,500 Per Family	
Lifetime Maximum	None	
Dependent Coverage	To age 26	
MEDICAL SERVICES	**Member Pays**	
PHYSICIAN SERVICES		
Office Visits (including Specialist)	$10 co-payment	30% after annual deductible
Hospital Visits	10%	30% after annual deductible
Emergency Room Visits	10%	10%
Urgent Care	10%	30% after annual deductible
Immunizations	No co-payment	30% after annual deductible
HOSPITAL SERVICES		
Room & Care – semi-private room rate; unlimited number of days	10%	30% after annual deductible
Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray	10%	30% after annual deductible
Emergency Room Facility	20%	20%
Ambulatory Surgical Center	$50 co-payment	30% after annual deductible
Maternity Services; semi-private room rate	10%	30% after annual deductible
Inpatient Surgery	10% for cutting	30% for cutting
	20% for non-cutting	30% for non-cutting
Inpatient Anesthesiologist	10%	30% after annual deductible
OUTPATIENT LABORATORY & X-RAY SERVICES		
Outpatient X-ray films, diagnostic services	20%	30% after annual deductible
Radiotherapy for malignancies and non-malignancies	20%	30% after annual deductible
MENTAL HEALTH SERVICES	**Member Pays**	
Inpatient Hospital & Facility Services; semi-private room rate	10%	30% after annual deductible
Inpatient Psychiatrist & Psychologist Services	10%	30% after annual deductible
Inpatient Psychological Testing	10%	30% after annual deductible
Outpatient Psychiatrist & Psychologist Services	10%	30% after annual deductible
Outpatient Psychological Testing	20%	20%
OTHER SERVICES*	**Member Pays**	
OTHER SERVICES*	* All benefits payable after application of annual deductible	
Ambulance	20%	30%
Air Ambulance (Limited to State of Hawaii)	20%	30%
Allergy Testing	20%	30%
Appliances & Equipment	20%	30%
Blood and Blood Products	20%	30%
Chemotherapy	20%	30%
Contraceptives (Contraceptive IUD, Implants and Injectables)	No co-payment	30%
Dialysis and Supplies	20%	30%
Evaluations for the Use of Hearing Aids	20%	30%
Organ Donor Services	20%	30%
Outpatient Injections	20%	30%
Physical/Occupational Therapy	20% Outpatient / 10% Inpatient No Deductible Applied	30%
Speech Therapy	20% Outpatient / 10% Inpatient No Deductible Applied	30%

PLAN PROVISIONS	Participating Providers	Non-Participating Providers
ACUPUNCTURE / CHIROPRACTIC SERVICES Member Pays		
There is a combined calendar year benefit maximum of $400.00 paid by the Plan for Acupuncture and Chiropractic Services.		
Acupuncture; Chiropractic Spinal Manipulation	$15 Co-payment per visit	$25 Co-payment per visit
Chiropractic: Office Visit (Examination), Radiology (Imaging), Physical Therapy	$10 Co-payment per visit	$15 Co-payment per visit
BENEFITS FOR CHILDREN Member Pays		
Newborn Circumcision	10%	30% after annual deductible
Well Child Care Office Visits (Up until age 5)	No co-payment	30%
Well Child Care Office Visits (Ages 6 through 18)	No co-payment	30%
Well Child Care Immunization	No co-payment	No co-payment
Well Child Care Lab Tests	No co-payment	30%
Student Physical Exam: Beneficiaries six (6) through eighteen (18) years of age are entitled to one (1) Student Physical Exam per calendar year as required by school. Student Physical Exams are not subject to the Annual Deductible. 90% Participating Providers / 70% Non-Participating Providers		
PREVENTIVE CARE Member Pays		
Preventive Care Services as required by the Affordable Care Act	No co-payment	30% after annual deductible
Pap Smears (One per calendar year [CY])	No co-payment	30%
Mammography (1 baseline age 35-39, 1 per CY age ≥ 40)	No co-payment	30%
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No co-payment	30%
VISION CARE SERVICES Plan Pays		
VISION EXAM – One per calendar year	100% of eligible charge after $10 annual deductible	Up to $40
LENSES	Only one of the following per calendar year	
Single	100% of eligible charge after $10 annual deductible	Up to $16
Multifocal	100% of eligible charge after $10 annual deductible	Up to $25
Contact Lenses	Up to $130 of eligible charge after $25 annual deductible	Up to $50
FRAMES – One frame every other calendar year	100% of eligible charge after $15 annual deductible (1)	Up to $12
(1) 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 the plan'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.		
PHARMACY BENEFITS Member Pays		
Annual Co-payment Maximum (1)	$4,100 Per Person, $5,700 Per Family	
Prescription Drugs (2)(3) (30 day supply)	Generic: $7 co-pay Preferred Brand:$15 co-pay Non-Preferred Brand: $30 co-pay	Generic: $25 co-pay Preferred Brand: $35 co-pay Non-Preferred Brand: $55 co-pay
Times, Preferred Network Pharmacies and Mail Order (3) (31-90 day supply)	Generic: $10 co-pay Preferred Brand: $20 co-pay Non-Preferred Brand: $50 co-pay	Member pays 100% of charges
Specialty Drugs (4) Must be dispensed through Pharmacare	$100 co-pay If the cost of the covered Specialty Drug exceeds $10,000, the co-pay is 20%, based on approved prior authorization.	Member pays 100% of charges

(1) You will not pay more than the annual co-payment maximum in a calendar year.
(2) There will be no reimbursements for members who go to a pharmacy other than Times Supermarkets.
(3) If the cost of the drug exceeds $5,000, the co-pay is 20%, based on approved prior authorization.
(4) All Specialty Drugs must be dispensed through Pharmacare. Step Therapy program applies.

All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician. Members on Kauai and Maui (3): If you use a pharmacy within our network of pharmacies on Kauai or Maui cost will be $7 co-pay per Generic Prescription, $15 co-pay per Preferred Brand Prescription and $30 co-pay per Non-Preferred Brand Prescription, $100 co-pay per Specialty Drug Prescription (4).

All plan benefits shown as a percentage of Eligible Charge. See the Summary Plan Description for a full description of benefits.

UFCW – HAWAII FOOD EMPLOYERS

HEALTH AND WELFARE FUND

UFCW HAWAII FOOD EMPLOYER HEALTH WELFARE AND TRUST FUND
Plan 1
(Actives and Retirees)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 1 coverage)	
	Participating Provider	Non Participating Provider
Annual Deductible	$100.00 per person/$300.00 per family (3 or more) (for Other Services)	
Annual Co-payment	$2,500.00 per person $7,500.00 per family (3 or more)	$2,500.00 per person $7,500.00 per family (3 or more)
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF, visits (Hosp inpt visits limited to one (1) per day)	90% of E.C.	80% of E.C. *
Well-Child Care 0-2 years (8 visits)	90% of E.C.	80% of E.C. *
Well-Child (1 visit each during ages 2-5 years)	90% of E.C.	80% of E.C. *
(Limited to two (2) tuberculin tests, two (2) blood tests (hemoglobin or hemtocrit), and one (1) urinalysis)		
Immunizations	90% of E.C. (Includes Well-Child Care)	80% of E.C. * (Includes Well-Child Care)
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumoniae.		
Effective 11/1/11: When received at any Safeway Pharmacy, the influenza vaccine is covered under the Plan with no copayment for Participants only. For a Dependent Spouse of Child, the influenza vaccine is covered under the Plan at the applicable copayment.		
HPV vaccine is covered for females (eff 07/01/07) and males (eff 08/01/14) when the first dose is administered to an 11-12 year old female or male with the second or third dose administered prior to 13 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administered by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	100% of E.C. (365 days maximum per Calendar Year)	80% of E.C. *
Intensive Care Unit, Coronary Care Unit	100% of E.C.	80% of E.C. *
Isolation Care Unit, Intermediate Care Unit	100% of E.C.	80% of E.C. *
Life Bed (Effective 01/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day *
Ancillary Services	90% of E.C.	80% of E.C. *
Emergency Room	100% of E.C. **Not covered if not a true emergency**	80% of E.C. *
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray Films and Radiotherapy for malignancy)	100% of E.C.	80% of E.C. *
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C. *
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	100% of E.C.	80% of E.C. *
Anesthesiologist	90% of E.C.	80% of E.C. *
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests, X-Ray Films and Radiotherapy for malignancy)	100% of E.C.	80% of E.C. *
Radiotherapy for non-malignancy	90% of E.C.	80% of E.C. *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

UFCW HAWAII FOOD EMPLOYER HEALTH WELFARE AND TRUST FUND
Plan 1
(Actives and Retirees)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 1 coverage)	
	Participating Provider	Non Participating Provider
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C. *
Mammography (Limited to one (1) baseline mammogram age 35-39 and one (1) mammogram every 12 months for ages 40 and above)	100% of E.C.	80% of E.C. *
Routine Pap Smear (Limited to one (1) per Calendar Year)	100% of E.C.	80% of E.C. *
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	100% of E.C.	80% of E.C. *
MATERNITY SERVICES		
Physicians Services	90% of E.C.	80% of E.C. *
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C.	80% of E.C. *
Birthing Center Services	100% of E.C.	80% of E.C. *
In Vitro Fertilization (Limited to one procedure per lifetime; In Vitro or Surrogacy)	90% of E.C. Physicians Services	80% of E.C. *
	100% of E.C. Labs & X-rays	80% of E.C. *
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	90% of E.C.	80% of E.C. *
Outpatient Physician Services	90% of E.C.	80% of E.C. *
Psychological Testing	90% of E.C.	80% of E.C. *
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.	90% of E.C.	80% of E.C. *
HOSPICE CARE SERVICES	(Up to 150 days per calendar year for a terminal illness)	
	100% of E.C.	Not Covered
HOME HEALTH CARE	(Up to 150 Home Health Care visits per calendar year)	
	100% of E.C.	80% of E.C. *
AMBULANCE SERVICES	**Not covered if not a true emergency**	
Automobile	90% of E.C.	80% of E.C. *
Air Shall be limited to inter-island transportation within the State of HI.	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	100% of E.C. after annual deductible	80% of E.C. after annual deductible *
Appliances & Equipment (DME) Includes hearing aids - one (1) device per ear every five (5) years	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C. after annual deductible	80% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

UFCW HAWAII FOOD EMPLOYER HEALTH WELFARE AND TRUST FUND
Plan 1
(Actives and Retirees)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 1 coverage)	
	Participating Provider	Non Participating Provider
Evaluations for Hearing Aids	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Chemotherapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Dialysis & Supplies	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
	(eff. 7/1/13 - E.C. for dialysis at 150% of Medicare eligible)	
Organ Donor Services	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Outpatient Injections	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Physical & Occupational Therapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Speech Therapy	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Surrogacy Health Benefits (eff. 06/01/12) (Limited to one procedure per lifetime; In Vitro or Surrogacy)	90% of E.C. Physicians Services	80% of E.C. *
	100% of E.C. Labs & X-rays	80% of E.C. *
	($5,000 maximum benefit on a primary or supplemental basis)	
Surrogacy Health Benefits are services the Surrogate receives related to conception, pregnancy or delivery related with a Surrogacy Arrangement. A Surrogacy Arrangement is one in which a Beneficiary agrees (by written agreement) to have another person, called Surrogate, carry a fertilized egg to delivery of the baby. Services for Surrogacy Health Benefits are covered for Surrogates of Beneficiaries, provided the Beneficiary has been covered under the Plan for 12 consecutive months immediately preceding the Surrogacy Arrangement.		
Nutrient Solutions	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
Smoking Cessation Clinic Service (For Participants only)	100% of E.C.	100% of E.C. *
IUD for Contraceptive Purposes	50% of E.C.	50% of E.C. after annual deductible *
	(Limited to one (1) IUD implant every five (5) years)	
PHYSICAL EXAMS	One per calendar year for participants & dependents	
For ages 6-12: (For preschool examination form 414)	100% of E.C.	100% of E.C. *
For ages 13-21: Includes: Complete history & physical exam, Audiogram-optional, Urinalysis, Blood count, Chest x-ray-optional (not more than once every 2 years)	100% of E.C.	100% of E.C. *
For ages 22-39: Includes: Complete history & physical exam, Audiogram-optional, Urinalysis, Blood count, Chest x-ray-optional (not more than once every 2 years)	100% of E.C. up to $115	100% of E.C. up to $115 *
For ages 40 and older: Includes: Complete history & physical exam, Audiogram-optional, Urinalysis, Blood count, Chest x-ray-optional (not more than once every 2 years), Biochemistry chemistry, Electrocardiogram (EKG 12 lead)	100% of E.C. up to $175	100% of E.C. up to $175 *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

UFCW HAWAII FOOD EMPLOYER HEALTH AND WELFARE TRUST FUND
Plan 2
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 2 coverage)	
	Participating Provider	**Non Participating Provider**
Annual Deductible	$50.00 per person $150.00 per family (3 or more)	$100.00 per person $300.00 per family (3 or more)
Annual Co-payment	$3,500.00 per person	$3,500.00 per person
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF visits (Hosp inpt visits limited to one (1) per day)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Well-Child Care 0-2 years (8 visits)	80% of E.C.	70% of E.C. *
Well-Child (1 visit each during ages 2-5 years)	80% of E.C.	70% of E.C. *
(Limited to two (2) tuberculin tests, two (2) blood tests (hemoglobin or hemtocrit), and one (1) urinalysis)		
Well-Child Immunizations	80% of E.C.	70% of E.C. *
Immunizations	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumoniae.		
Effective 11/1/11: When received at any Safeway Pharmacy, the influenza vaccine is covered under the Plan with no copayment for Participants only. For a Dependent Spouse of Child, the influenza vaccine is covered under the Plan at the applicable copayment.		
HPV vaccine is covered for females (eff 07/01/07) and males (eff 08/01/14) when the first dose is administered to an 11-12 year old female or male with the second or third dose administered prior to 13 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administered by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	90% of E.C. after annual deductible (365 days maximum per Calendar Year)	70% of E.C. after annual deductible *
Intensive Care Unit, Coronary Care Unit	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Isolation Care Unit, Intermediate Care Unit	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Life Bed (Effective 06/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day *
Ancillary Services	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Emergency Room	90% of E.C. after annual deductible **Not covered if not a true emergency**	70% of E.C. after annual deductible *
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests and X-Ray Films)	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Radiotherapy for non-malignancy	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
SURGICAL SERVICES		
Surgery-Cutting & Non Cutting Inpatient or Outpatient	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Anesthesiologist	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
OUTPATIENT LABORATORY & X-RAY SERVICES Services ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests and X-Ray Films)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Radiotherapy for non-malignancy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

UFCW HAWAII FOOD EMPLOYER HEALTH AND WELFARE TRUST FUND
Plan 2
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 2 coverage)	
	Participating Provider	**Non Participating Provider**
Mammography	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
(Limited to one (1) baseline mammogram age 35-39 and one mammogram every 12 months for ages 40 and above)		
Routine Pap Smear	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
(Limited to one (1) per Calendar Year)		
Prostate Specific Antigen	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
(Limited to one (1) per Calendar Year for men ages 50 and above)		
MATERNITY SERVICES		
Physicians Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C. after annual deductible	70% of E.C. after annual deductible *
Birthing Center Services	100% of E.C. after annual deductible	70% of E.C. after annual deductible *
In Vitro Fertilization	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
(Limited to one procedure per lifetime; In Vitro or Surrogacy)	Physicians Services	
	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
	Labs & X-rays	
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Outpatient Physician Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Psychological Testing	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.		
HOSPICE CARE SERVICES	(Up to 150 days per calendar year for a terminal illness)	
	80% of E.C. after annual deductible	Not Covered
HOME HEALTH CARE	(Up to 150 Home Health Care visits per calendar year)	
	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
AMBULANCE SERVICES		
	Not covered if not a true emergency	
Automobile	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Air	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Services shall be limited to inter-island transportation within the State of HI		
OTHER BENEFITS		
Allergy Testing	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
(Limited to one (1) series of tests per Calendar Year)		
Appliances & Equipment (DME)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Includes hearing aids - one (1) device per ear every five (5) years		
Blood and Blood Products	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
including blood costs, blood bank services, blood processing		
Evaluations for Hearing Aids	80% of E.C. after annual deductible	70% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

Benefits	Comprehensive Self-Funded Medical Plan (Plan 2 coverage)	
	Participating Provider	Non Participating Provider
Chemotherapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Dialysis & Supplies	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
	(eff. 7/1/13 - E.C. for dialysis at 150% of Medicare eligible)	
Organ Donor Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Outpatient Injections	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Physical & Occupational Therapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible
Speech Therapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Surrogacy Health Benefits (eff. 06/01/12) (Limited to one procedure per lifetime; In Vitro or Surrogacy)	80% of E.C. after annual deductible Physicians Services	70% of E.C. after annual deductible *
	80% of E.C. after annual deductible Labs & X-rays	70% of E.C. after annual deductible *
	($5,000 maximum benefit on a primary or supplemental basis)	
Surrogacy Health Benefits are services the Surrogate receives related to conception, pregnancy or delivery related with a Surrogacy Arrangement. A Surrogacy Arrangement is one in which a Beneficiary agrees (by written agreement) to have another person, called Surrogate, carry a fertilized egg to delivery of the baby. Services for Surrogacy Health Benefits are covered for Surrogates of Beneficiaries, provided the Beneficiary has been covered under the Plan for 12 consecutive months immediately preceding the Surrogacy Arrangement.		
Nutrient Solutions	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Smoking Cessation Clinic Service (For Participants only)	100% of E.C.	100% of E.C. *
IUD for Contraceptive Purposes	50% of E.C.	50% of E.C. *
	(Limited to one (1) IUD implant every five (5) years)	
PHYSICAL EXAMS	For Participants only	
For ages under 22: (Once every 2 years) Includes: Complete history & physical exam, Urinalysis, Blood count, Blood cholesterol, Blood glucose, Stool occult blood, Chest x-ray (once up to age 40), Electrocardiogram (EKG 12 lead) (once up to age 40)	100% of E.C.	100% of E.C. *
For ages 22 through 39: (Once every 2 years) Includes: Complete history & physical exam, Urinalysis, Blood count, Blood cholesterol, Blood glucose, Stool occult blood, Blood chemistry panel, Chest x-ray (once up to age 40), Electrocardiogram (EKG 12 lead) (once up to age 40)	100% of E.C. up to $190	100% of E.C. up to $190 *
For ages 40 and over: (Once every year) Includes: Complete history & physical exam, Urinalysis, Blood count, Blood cholesterol, Blood glucose, Stool occult blood, Blood chemistry panel, Chest x-ray (once per year), Electrocardiogram (EKG 12 lead) (once every 2 years), Glaucoma testing (if not done with vision exam), Sigmoidoscopy (once every 5 years starting at age 50)	100% of E.C. up to $255	100% of E.C. up to $255 *
(Note: Prior authorization is required; reimbursement is not subject to maximum allowance when prior authorization is obtained)		

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

UFCW HAWAII FOOD EMPLOYER HEALTH AND WELFARE TRUST FUND
Plan 3
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 3 coverage)	
	Participating Provider	**Non Participating Provider**
Annual Deductible	$50.00 per person $150.00 per family (3 or more)	$100.00 per person $300.00 per family (3 or more)
Annual Co-payment	$3,500.00 per person	$3,500.00 per person
Annual Maximum	No Limit	No Limit
Lifetime Maximum	No Limit	No Limit
PHYSICIAN SERVICES		
Home, Office, Hospital, ER, SNF, visits (Hosp inpt visits limited to one (1) per day)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Immunizations	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Immunizations for cholera, diphtheria, hepatitis, influenza, measles, mumps, rubella, whooping cough, polio, smallpox, tetanus, typhoid, typhus chicken pox, and streptococcus pneumoniae.		
Effective 11/1/11: When received at any Safeway Pharmacy, the influenza vaccine is covered under the Plan with no copayment for Participants only.		
HPV vaccine is covered for females (eff 07/01/07) and males (eff 08/01/14) when the first dose is administered to an 11-12 year old female or male with the second or third dose administered prior to 13 years of age.		
Effective 10/1/07: **Meningococcal** vaccine is covered from the age of 11 years old. Those younger than 11 years old will require prior auth. **Rotavirus** vaccine is covered when the first dose is administered to an infant by 12 weeks of age and the remaining two doses administered by 32 weeks of age.		
HOSPITAL INPATIENT SERVICES		
Room & Care (Semiprivate room rate)	90% of E.C. after annual deductible (365 days maximum per Calendar Year)	70% of E.C. after annual deductible *
Intensive Care Unit, Coronary Care Unit	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Isolation Care Unit, Intermediate Care Unit	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Life Bed (Effective 06/01/08)	Covered at an E.C. of $18.00 per day	Covered at an E.C. of $18.00 per day *
Ancillary Services	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Emergency Room	90% of E.C. after annual deductible **Not covered if not a true emergency**	70% of E.C. after annual deductible *
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests and X-Ray Films)	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
Radiotherapy for non-malignancy	90% of E.C. after annual deductible	70% of E.C. after annual deductible *
SURGICAL SERVICES		
Surgery Cutting & Non Cutting Inpatient or Outpatient	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Anesthesiologist	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
OUTPATIENT LABORATORY & X-RAY SERVICES Service ordered by a physician for the diagnosis of an injury or illness		
Laboratory and X-ray services (Laboratory Services, Diagnostic Tests and X-Ray Films)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Radiotherapy for non-malignancy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Tuberculin Tine Test (Limited to one (1) per Calendar Year)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Mammography (Limited to one (1) baseline mammogram age 35-39 and one mammogram every 12 months for ages 40 and above)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Routine Pap Smear (Limited to one (1) per Calendar Year)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorizations list.

UFCW HAWAII FOOD EMPLOYER HEALTH AND WELFARE TRUST FUND
Plan 3
(Actives)

Benefits	Comprehensive Self-Funded Medical Plan (Plan 3 coverage)	
	Participating Providers	Non Participating Providers
Prostate Specific Antigen (Limited to one (1) per Calendar Year for men ages 50 and above)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
MATERNITY SERVICES		
Physicians Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Hospital Services	See Hospital Benefits	
Nurse-Midwife Services	100% of E.C. after annual deductible	70% of E.C. after annual deductible *
Birthing Center Services	100% of E.C. after annual deductible	70% of E.C. after annual deductible *
INPATIENT/OUTPATIENT MENTAL ILLNESS SERVICES		
Inpatient Hospital & Facility Services	See Hospital Benefits	
Inpatient Physician Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Outpatient Physician Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Psychological Testing	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
SKILLED NURSING FACILITY	(Up to 120 days in any one Calendar Year) Room & board based on semi private room rate	
Inpatient Services Services and supplies are covered, including routine surgical supplies drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services.	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
HOSPICE CARE SERVICES	(Up to 150 days per calendar year for a terminal illness)	
	80% of E.C. after annual deductible	Not Covered
HOME HEALTH CARE	(Up to 150 Home Health Care visits per calendar year)	
	80% of E.C. after annual deductible	80% of E.C. after annual deductible *
AMBULANCE SERVICES	**Not covered if not a true emergency**	
Automobile	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Air Services shall be limited to inter-island transportation within the State of HI	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
OTHER BENEFITS		
Allergy Testing (Limited to one (1) series of tests per Calendar Year)	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Appliances & Equipment (DME) Includes hearing aids - one (1) device per ear every five (5) years	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Blood and Blood Products Including blood costs, blood bank services, blood processing	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Evaluations for Hearing Aids	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Chemotherapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Dialysis & Supplies	80% of E.C. after annual deductible (eff. 7/1/13 - E.C. for dialysis at 150% of Medicare eligible)	70% of E.C. after annual deductible *
Organ Donor Services	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Outpatient Injections	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Physical & Occupational Therapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *
Speech Therapy	80% of E.C. after annual deductible	70% of E.C. after annual deductible *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits and prior authorization list.

Benefits	Comprehensive Self-Funded Medical Plan (Plan 3 coverage)	
	Participating Providers	Non Participating Providers
Smoking Cessation Clinic Services (For Participant only)	100% of E.C.	100% of E.C. *
IUD for Contraceptive Purposes	50% of E.C. (Limited to one (1) IUD implant every five (5) years)	50% of E.C. *
PHYSICAL EXAMS	For Participants only; Annual deductible does not apply to this benefit	
For ages under 22: (Once every 2 years) Includes: Complete history & physical exam Urinalysis Blood count Blood cholesterol Blood glucose Stool occult blood Chest x-ray (once up to age 40) Electrocardiogram (EKG 12 lead) (once up to age 40)	100% of E.C.	100% of E.C. *
For ages 22 through 39: (Once every 2 years) Includes: Complete history & physical exam Urinalysis Blood count Blood cholesterol Blood glucose Stool occult blood Chest x-ray (once up to age 40) Electrocardiogram (EKG 12 lead) (once up to age 40)	100% of E.C. up to $190	100% of E.C. up to $190 *
For ages 40 and over: (Once every year) Includes: Complete history & physical exam Urinalysis Blood count Blood cholesterol Blood glucose Stool occult blood Blood chemistry panel Chest x-ray (once per year) Electrocardiogram (EKG 12 lead) (once every 2 years) Glaucoma testing (if not done with vision exam) Sigmoidoscopy (once every 5 years starting at age 50) (Note: Prior authorization is required; reimbursement is not subject to maximum allowance when prior authorization is obtained)	100% of E.C. up to $255	100% of E.C. up to $255 *

* Member owes any difference between the actual charges and eligible charges (E.C.)
NOTE: This is a summary of benefits. Please contact HMA Customer Service for a full description of benefits.

FORMS

HMA

Hawaii-Mainland Administrators

Hawaii-Mainland Administrators

1440 Kapiolani Blvd, Suite #1020, Honolulu, Hawaii 96814
HMA: Phone: (808) 951-4621 or Toll Free: (866) 377-3977

Please fax all requests to: 866-206-5655

PRIOR AUTHORIZATION FORM

Referring Provider or Primary Care Physician		
Address of Referring Provider or Primary Care Physician		
Name of Office Contact Person:	**Phone:**	**Fax:**
PATIENT INFORMATION		
Patient Name:	**Date of Birth:**	**Sex:** _____ F _____M
Patient ID#:	**Primary Insurance:**	
Patient's Phone:		
Address:		
Other Insurance (Third Party Liability, Workmen's Compensation):		
Date of Injury:		
TREATING SPECIALIST OR TREATING FACILITY INFORMATION		
Name of Treating Specialist or Facility:		
Address of Treating Specialist or Facility:		
Name of Office Contact Person:	**Phone:**	**Fax:**
Service(s) Requested:	**# of Units or Treatments Requested:**	**Requested Dates of Service:**
Diagnosis:		☐ **Inpatient** ☐ **Outpatient**
Optional: ICD 9:	**CPT Code:**	**HCPC Code:**

Prior authorization is based on the medical necessity of the services requested. Actual benefit payment is contingent on eligibility and the provision of the medical plan. The subscriber or their dependents, together with his of her physician is ultimately responsible for determining the appropriate course of medical treatment, regardless of what the plan will pay.

HMA
Hawaii-Mainland Administrators

Telephone: 808.951.4621 / Toll Free: 866.377.3977 / Fax: 866.206.5655

Behavioral Health Interpretive Summary / Treatment Plan

Member's Name	Date of Service Requested:	Authorization # (if applicable):
Member's ID#		

Complaint:

History of Present Illness / Symptoms:

Past Psychiatric History:

Current Medications:

DSM-IV Diagnosis

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	Current GAF: Past GAF:

Goals:

Treatment Modalities:

Treatment Frequency:

Provider Name (Please Print)	Provider Signature	Date Signed