Hawaii Farm Bureau Federation

BENEFIT PLAN COMPARISON

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

Important Information

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

For Health Plan Hawaii, HMSA requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as their PCP.

Women do not need prior authorization from HMSA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in their health center who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Services from a non-network provider are not covered with the exception of emergency care and/or referrals from your in-network PCP.

For information on how to select a PCP or a list of participating health care professionals who specialize in obstetrics or gynecology, visit hmsa.com/search/providers. If you require a hard copy listing, please visit an HMSA office nearest you or call HMSA Customer Service at 948-6372 on Oahu or toll-free at 1-800-776-4672.

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

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

Note: Asterisk * = Indicates annual deductible applies.

PLAN PROVISIONS	PREFERRED PROVIDER PLAN 2010 (800)		COMPMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited
Annual Copayment Maximum	$2,500 per person Maximum: $7,500 per family		$2,500 per person Maximum: $7,500 per family		$2,500 per person Maximum: $7,500 per family
Annual Deductible	None	$100 per person Maximum:$300 per family	None		None

MEDICAL SERVICES	PREFERRED PROVIDER PLAN 2010 (800)		COMPMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
PHYSICIAN SERVICES					
Office Visits	$12[1]	30%*	$14[1]	$14[1]	$15
Hospital Visits	$12[1]	30%*	$20[1]	$20[1]	$15 (hospital outpatient) None (hospital inpatient)
Emergency Room	$12[1]	$12[1]	$20[1]	$20[1]	None
HOSPITAL AND FACILITY SERVICES					
Hospital Room and Board; Semiprivate Room Rate; unlimited number of days	10%	30%*	20%	20%	$75 per day
Hospital Ancillary	10%	30%*	20%	20%	None
Intensive Care Unit; Coronary Care Unit	10%	30%*	20%	20%	$75 per day
Emergency Room	$75[1]	$75[1]	$100[1]	$100[1]	$75
SURGICAL SERVICES					
Surgical Procedures	10% (cutting) 20% (non-cutting)	30%*	20%	20%	None (outpatient surgical center) $15 (outpatient professional charges) None (hospital operating room) None (inpatient professional charges)
Anesthesia	10%	30%*	20%	20%	$15 (outpatient professional charges) None (inpatient professional charges)
LABORATORY AND RADIOLOGY					
Diagnostic Testing	20% (outpatient) 10% (inpatient)	30%*	20%	20%	10% (office visit) 10% (hospital outpatient) None (hospital inpatient)
Laboratory and Pathology	20% (outpatient) 10% (inpatient)	30%*	None (outpatient) 20% (inpatient)	None (outpatient) 20% (inpatient)	10% (office visit) 10% (hospital outpatient) None (hospital inpatient)
X-Ray and Other Radiology	20% (outpatient) 10% (inpatient)	30%*	20%	20%	10% (office visit) 10% (hospital outpatient) None (hospital inpatient)
Radiation Therapy for Malignancies and Non-malignancies	20% (outpatient) 10% (inpatient)	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)

[1] This amount does not include tax.

MEDICAL SERVICES	PREFERRED PROVIDER PLAN 2010 (800)		COMPMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
OTHER MEDICAL SERVICES					
Allergy Testing	20%	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Ambulance (air)	20%	30%*	20%	20%	20%
Ambulance (ground)	20%	30%*	20%	20%	20%
Blood and Blood Products	20%	30%*	20%	20%	None
Chemotherapy - Infusion / Injections	20%	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Dialysis and Supplies	20%	30%*	20%	20%	10% (hospital outpatient) None (hospital inpatient)
Hospice	None	Not covered	None	None	None
Injections	20%	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Inter-island Transportation	Not covered	Not covered	Not covered	Not covered	None
Medical Equipment, Appliances and Supplies	20%	30%*	20%	20%	50% (external devices) None (internal devices)
Organ Donor Services	20%	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Organ and Tissue Transplant	None [2]	Not covered	None[3]	None[3]	$15 (office visit) [2] $15 (hospital outpatient) [2] None (hospital inpatient) [2]
Physical and Occupational Therapy	20% (outpatient) 10% (inpatient)	30%*	20%	20%	$15 (office visit) $15 (hospital outpatient) None (hospital inpatient)
Speech Therapy Services	20% (outpatient) 10% (inpatient)	30%*	20%	20%	$15 (outpatient) None (inpatient)
Vision Exam	Refer to Vision plan for examination benefits		Refer to Vision plan for examination benefits		$15 (One exam per calendar year)

SPECIAL BENEFITS	PREFERRED PROVIDER PLAN 2010 (800)		COMPMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
BENEFITS FOR CHILDREN					
Newborn Circumcision	10%	30%*	10%	10%	Regular Plan Benefits
Well Child Care Immunizations (through age 21)	None	None	None	None	None
Well Child Care Laboratory (through age 21)	None	30%	None	None	None
Well Child Care Physician Office Visits (through age 21)	None	30%	None	None	None
BENEFITS FOR MEN					
Prostate Specific Antigen (PSA) Test (screening)	20%	30%*	None	None	Regular Plan Benefits
Vasectomy	10%	30%*	20%	20%	Regular Plan Benefits
BENEFITS FOR WOMEN					
Contraceptives[4]					
Implants	50%	50%	20%	20%	50%
IUD	50%	50%	20%	20%	50%
Injectables	50%	50%	20%	20%	50%[5]
Mammography (screening)	None	30%	None	None	None
Pap Smears (screening)	None	30%*	None	None	None
Maternity Care	Regular Plan Benefits	Regular Plan Benefits	10% (Includes facility & inpatient ancillary services)	10%	Regular Plan Benefits
Well Woman Exam	None	30%*	None	None	None

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

[3] This benefit includes transplants such as: stem-cell (including bone marrow), heart, heart and lung, liver, lung, pancreas, simultaneous kidney/pancreas and small bowel and multivisceral. Refer to your Guide to Benefits for information on other transplants.

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

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

SPECIAL BENEFITS	PREFERRED PROVIDER PLAN 2010 (800)		COMPMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
PHYSICAL EXAMS	Not covered	Not covered	Not covered	Not covered	None
SCREENING SERVICES[6]	None	30%*	None	None	None
DISEASE MANAGEMENT AND PREVENTIVE SERVICES PROGRAMS	None	Not covered	None	Not covered	None
ONLINE CARE	As an HMSA member, you and your covered dependents may access HMSA's Online Care through www.hmsa.com. Your copayment is $10 for up to 10 minutes; $5 for an additional 5 minute extension. Each session is limited to a total of 15 minutes.				
HEALTH ASSESSMENT (HealthPass)	As an HMSA member, you and your covered dependents age 14 and older are entitled to HealthPass, a free annual health assessment from a contracted HealthPass provider that evaluates your health and lifestyle. The program provides professional counseling to help you design a personal health action program that fosters healthy behavior.				
HE HAPAI PONO - The Good Pregnancy (Prenatal Care Management Program)	A program that offers guidance in receiving the appropriate care throughout the duration of your pregnancy and up to six weeks after the baby is born. You will receive specialized telephonic support from clinicians as needed to enhance traditional office-based care, along with links to other resources in the community. Includes written information specific to your needs, as well as a free pregnancy or baby care book				
POSITIVELY PREGNANT (Pregnancy Workshop)	Free workshops open to all pregnant women and their partners, or women thinking about starting a family. You will be given information on appropriate prenatal care, taught how to look for signs and symptoms of complications and what to do if they occur. Includes a free pregnancy guide for all members.				
HMSA'S CARE CONNECTION					
For Asthma, COPD, Diabetes, Heart Disease and CKD	Chronic disease management support services including regular care calls from a team of specially trained clinicians, medication review, educational newsletters, reminders for important tests and screenings and strategies to engage in a healthy, active life. Members with diabetes are also eligible to attend diabetes education classes from select participating providers at no additional cost.				
BEHAVIORAL HEALTH (Mental Health & Substance Abuse)	Screenings for depression and substance abuse, educational materials, referrals to participating providers and treatment centers, and case management services if needed.				
READY, SET, QUIT!	Personalized stop-smoking program including free private telephonic counseling for up to 18 months, education on therapies and strategies from a care specialist, and referrals to community resources				

[6] U.S. Preventive Services Task Force Recommended Grade A & B Screenings

FOR DIABETIC SUPPLIES, INSULIN AND ADDITIONAL CONTRACEPTIVES PLEASE REFER TO YOUR DRUG SECTION

PRESCRIPTION DRUG	DRUG 515		DRUG 516	
	YOUR COPAYMENT		YOUR COPAYMENT	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
GENERIC (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$7	$7 plus 20% of remaining eligible charge	$7	$7 plus 20% of remaining eligible charge
PREFERRED BRAND NAME & SINGLE SOURCE GENERIC DRUGS (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$30	$30 plus 20% of remaining eligible charge	$30	$30 plus 20% of remaining eligible charge
OTHER BRAND NAME (Includes Oral Contraceptives and Other Contraceptive Methods) [7]	$30 plus $45 Other Brand Name cost share	$30 plus $45 Other Brand Name cost share and 20% of remaining eligible charge	$30 plus $45 Other Brand Name cost share	$30 plus $45 Other Brand Name cost share and 20% of remaining eligible charge
SPECIALTY DRUGS	$100[8]	Not covered	$100[8]	Not covered
U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS[9]	None	20%	None	20%
ORAL CHEMOTHERAPY DRUGS	None	None	None	None
INSULIN				
Preferred Brand Name	$7	$7 plus 20% of remaining eligible charge	$7	$7 plus 20% of remaining eligible charge
Other Brand Name	$30	$30 plus 20% of remaining eligible charge	$30	$30 plus 20% of remaining eligible charge
DIABETIC SUPPLIES				
Preferred Brand Name	None	None	None	None
Other Brand Name	$30	$30	$30	$30
ADDITIONAL BENEFITS				
Contraceptives Diaphragms (per device)	$10	$10	$10	$10
Smoking Cessation Drugs Treatment is limited to: 180 days per calendar year	None	20%	None	20%
Spacers and Peak Flow Meters for Inhaled Drugs[10]	None	None	None	None

- **NOTE:** Each drug dispensed is limited to a 30-day supply. A 30-day supply is defined as a supply lasting the member for a period consisting of 30 consecutive days.

MAIL SERVICE PRESCRIPTION PROGRAM (From an HMSA contracted provider -- 90 day supply)				
GENERIC[11]	$11	Not covered	$11	Not covered
PREFERRED BRAND NAME	$65	Not covered	$65	Not covered
OTHER BRAND NAME	$65 plus $135[12] Other Brand Name cost share	Not covered	$65 plus $135[12] Other Brand Name cost share	Not covered
SPECIALTY DRUGS	Not covered	Not covered	Not covered	Not covered
U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS[9]	None	Not covered	None	Not covered
ORAL CHEMOTHERAPY DRUGS	None	Not covered	None	Not covered
INSULIN				
Preferred Brand Name	$11	Not covered	$11	Not covered
Other Brand Name	$65	Not covered	$65	Not covered
DIABETIC SUPPLIES				
Preferred Brand Name	None	Not covered	None	Not covered
Other Brand Name	$65	Not covered	$65	Not covered

- **NOTE:** When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy.

(7) See Additional Benefits section for Contraceptive Diaphragms.

(8) Benefit available at Par Specialty Pharmacies only.

(9) USPSTF A & B Recommendations

(10) Limited to the items on HMSA's SELECT formulary

(11) Includes Single Source Generic Drugs

(12) $45 retail Other Brand Name cost share times 3 month supply

VISION CARE SERVICES	VISION AI		VISION CK	
	YOUR COPAYMENT		YOUR COPAYMENT	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
EYE EXAMINATION One per calendar year	$10 annual deductible	All charges less $40 plan payment	Refer to Medical Plan for Examination Benefits	Not covered
LENSES (One of the following) One pair per calendar year:				
Single	$10 annual deductible	All charges less $16 plan payment	$10 member copayment	All charges less $16 plan payment
Multifocal	$10 annual deductible	All charges less $25 plan payment	$10 member copayment	All charges less $25 plan payment
Contact Lenses	$25 annual deductible plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment	$25 member copayment plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment
ADDITIONAL BENEFITS				
Polycarbonate Lenses (For children through age 18); One pair per calendar year	None	All charges less $18 plan payment	None	All charges less $18 plan payment
Contact Lens Fitting; One fitting per calendar year	All charges less $45 plan payment	All charges less $20 plan payment	All charges less $45 plan payment	All charges less $20 plan payment
FRAMES One frame every 24 months	$15 annual deductible	All charges less $12 plan payment	$15 member copayment	All charges less $12 plan payment

NOTES:

- Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between HMSA's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of lenses and contact lenses.
- If the member receives benefits for contact lenses, the member is not eligible for frames in the same year. If benefits for frames have been paid in a calendar year, those benefits will be deducted from the benefits for any contact lenses furnished in the same calendar year.
- Exclusions: Sunglasses, prescription inserts for diving masks and any protective eyewear, nonprescription industrial safety goggles, nonstandard items for lenses, including tinting, blending, oversized lenses, invisible bifocals or trifocals, and repair and replacement of frame parts and accessories.
- Contact lenses following cataract surgery are not a benefit.

CHIROPRACTIC CARE	CHIRO A
	YOUR COPAYMENT
Office Visits (Up to 12 visits per calendar year)	All charges less $10 per visit plan payment
X-ray films (Plan pays up to $50 per calendar year for x-ray films of the spine)	50%

- **NOTE:** To be eligible for payment, chiropractic services must be necessary for the diagnosis and treatment of an injury or illness of the back or spine and performed by a properly licensed or certified chiropractor.