

#3 - RCUH HMSA MEDICAL PLAN SUMMARY - PLAN YEAR JULY 1, 2010 – JUNE 30, 2011

BENEFITS	HEALTH PLAN HAWAII PLUS (HHPH)	HEALTH PLAN HAWAII BASIC (HHP-B)	PREFERRED PROVIDER PLAN (PPO)	COMPREHENSIVE MEDICAL (CompMED)
For more details: Oahu/948-6111; Maui/871-6295; Hilo/935-5441; Kona/329-5291; Kauai/245-3393; others 1 (800) 648-3190				
Coverage	Oahu, Maui, Hawaii, Kauai, Molokai, Lanai	Oahu, Maui, Hawaii, Kauai, Molokai, Lanai	Worldwide	Worldwide
Annual Deductible	None	None	Other Services & Non-par \$100/person; \$300/family	None
Out of Pocket Maximum (Annual)	\$1,500 Individual/\$4,500 Family	\$2,000 Individual/\$6,000 Family	\$2,500 Individual/\$7,500 Family	\$2,500 Individual/\$7,500 Family
Lifetime Maximum	Unlimited	Unlimited	\$1,000,000	Unlimited
Physicians Services: Office Visits & Surgery – Outpatient Hospital Visits & Surgery – Inpatient	You pay \$14 No Charge	You pay \$15 You pay \$15	You pay 10% par / 30% non-par You pay 10% par / 30% non-par Cutting: 10% par / 30% non-par Non-Cutting: 20% par / 30% non-par	You pay \$14 (office visit)* You pay \$20 (hospital visit)* / Surgery 20% of eligible charges**
Inpatient Hospital Services: Room & Board, Ancillary (includes Lab & X-Ray)	No Charge (based on semi-private room)	You pay 20% (based on semi-private room)	You pay 10% par / 30% non-par based on semi-private room	You pay 20% of eligible charges** based on semi-private room
Outpatient Diagnostic, Lab, X-Ray & Radiotherapy	No Charge for Diagnostic/Lab You pay 10% for X-Ray You pay \$14 for Radiotherapy	No Charge for Diagnostic/Lab You pay 10% for X-Ray You pay \$15 for Radiotherapy	You pay 20% par / 30% non-par	You pay 20% of eligible charges** No charge for Laboratory Services
Physicals	No Charge	No Charge	Not covered other than Health Pass	Not covered other than Health Pass
Maternity – Office Visits	You pay \$14/visit	You pay \$15	You pay 10% par / 30% non-par	You pay \$14/visit
Maternity – Inpatient (based on semi private room)	No Charge (based on semi-private room)	You pay 20% (based on semi-private room)	You pay 10% par / 30% non-par	Plan covers 90% (Based on semi-private room)
Preventive Care (Pap Smears, Mammography, Prostate Specific Antigen - PSA)	No Charge for Pap Smears, Mammography PSA –Regular Plan Benefits	No Charge for Pap Smears, Mammography PSA –Regular Plan Benefits	You pay 20% par / 30% non-par	No Charge
Well Baby Care	No Charge	No Charge	Well Baby Immunization plan pays 100%; Well Baby Visits you pay 10% par/30% non-par	Plan pays 100% of eligible charges**
Emergency Room Facility	You pay \$25 each visit at ER; outside of HI 20% of eligible charges.	You pay \$50 each visit at ER; outside of HI 20% of eligible charges.	You pay 10% par / 10% non-par	You pay \$100 per visit*
Urgent Care	You pay \$14 at PCP office	You pay \$15 at PCP office	You pay 10% par / 30% non-par	You pay \$14 (same as office visit)*
Ambulance	You pay 20%	You pay 20%	You pay 20% par / 30% non-par	You pay 20% of eligible charges**
Mental Health Outpatient	You pay \$14 per visit	You pay \$15 per visit	You pay 10% par / 30% non-par	You pay \$14 per visit*
Mental Health Inpatient (Hospital based on semi-private room)	Hospital: Plan pays 100% Physician Services: Plan pays 100%	Hospital: Plan pays 80% Physician Services: \$15 copay	You pay 10% par / 30% non-par	Hospital: Plan pays 80% of eligible charges** Physician Services: You pay \$20 per visit*
DRUG PLAN Drug Plan Select (Same Drug Plan for all HMSA Medical plans)				
Prescription Drugs	Generic: \$10 co-payment; Preferred Brand: \$15 co-payment; Other Brand \$15 co-pay plus; \$35 Other Brand Name cost share. Co-payments apply to participating pharmacies only. (30 day supply)			
Mail Order Maintenance Med (Up to 90 day supply)	Generic: \$10 copay; Preferred Brand \$20 copay; Other Brand \$20 copay plus \$105 Other Brand Name cost share. Participating vendor only.			
VISION PLAN Vision Plan A1 (Same Vision Plan for all HMSA Medical plans)				
Vision Visit (one per calendar year)	You pay \$10 (Vision rates apply to Participating HMSA Providers)			
Standard Lenses	1 pair lenses or 1 pair contacts per calendar year			
Frame	You pay \$10			
Contact Lenses	You pay \$15 one frame every 24 months (frames must be chosen from selection)			
Professional Fees (for contact lenses fitting)	You pay \$25 (plan pays up to \$130)			
	Plan pays up to \$45 (one per calendar year)			
Premium Cost (Per Month)	HEALTH PLAN HAWAII PLUS	HEALTH PLAN HAWAII	PREFERRED PROVIDER PLAN	COMPREHENSIVE MEDICAL
Single Plan	Employee + (Employer) = Total \$134.08 (\$201.12) = \$335.20	Employee + (Employer) = Total \$108.81 (\$163.21) = \$272.02	Employee + (Employer) = Total \$134.08 (\$201.12) = \$335.20	Employee + (Employer) = Total \$112.34 (\$168.50) = \$280.84
2-Party Plan	\$268.16 (\$402.24) = \$670.40	\$217.61 (\$326.41) = \$544.02	\$268.16 (\$402.24) = \$670.40	\$224.66 (\$337.00) = \$561.66
3+ Family Plan	\$463.90 (\$695.86) = \$1159.76	\$376.46 (\$564.68) = \$941.14	\$463.90 (\$695.86) = \$1,159.76	\$388.66 (\$583.00) = \$971.66

All PLAN BENEFITS ARE BASED ON ELIGIBLE CHARGE. *This amount does not include tax; **Eligible charges are the amount that HMSA's Participating Providers have agreed to accept as payment in full for services rendered. 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 charges & the nonparticipating provider's actual charges.

NOTE: This is a high level summary & does not contain complete information. Please refer to plan certificate for complete information on benefits & provisions