#3 - RCUH HMSA MEDICAL PLAN SUMMARY - PLAN YEAR JULY 1, 2011 – JUNE 30, 2012

BENEFITS	HEALTH PLAN HAWAII PLUS (HPHP)	HEALTH PLAN HAWAII BASIC (HPH-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	Unlimited	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** for Inpatient & Radiotherapy No charge for Outpatient
Physicals	No Charge	No Charge	Not covered other than Health Pass	Not covered other than Health Pass
Maternity – Office Visits Maternity – Inpatient (based on semi private room)	You pay $14/visit No Charge (based on semi-private room)	You pay $15 You pay 20% (based on semi-private room)	You pay 10% par / 30% non-par You pay 10% par / 30% non-par	You pay $14/visit 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; $25 outside of HI par; 20% of eligible charges outside of HI non-par.	You pay **$50** each visit at ER; $50 outside of HI par; 20% of eligible charges outside of HI non-par.	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 – physician visit	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: Plan pays 100%	You pay 10% par / 30% non-par	Hospital: Plan pays 80% of eligible charges** Physician Services: Plan pays 100%
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 Frame Contact Lenses Professional Fees (for contact lenses fitting)	1 pair lenses or 1 pair contacts per calendar year You pay $10 You pay $15 one frame every 24 months (frames must be chosen from selection) 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**
	Employee + (Employer) = *Total*	**Employee +** (Employer) = *Total*	**Employee +** (Employer) = *Total*	**Employee +** (Employer) = *Total*
Single Plan	**$141.77** ($212.65) = *$354.42*	**$115.30** ($172.96) = *$288.26*	**$141.77** ($212.65) = *$354.42*	**$119.00** ($178.50) = *$297.50*
2-Party Plan	**$283.52** ($425.28) = *$708.80*	**$230.59** ($345.89) = *$576.48*	**$283.52** ($425.28) = *$708.48*	**$237.98** ($356.98) = *$594.96*
3+ Family Plan	**$490.49** ($735.73) = *$1,226.22*	**$398.93** ($598.39) = *$997.32*	**$490.49** ($735.73) = *$1,226.22*	**$411.71** ($617.57) = *$1,029.28*

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

*Grandfathered Coverage: RCUH believes coverage under the HMSA Service Agreement is a "grandfathered health plan" under the Patient Protection and Affordability Care Act. Questions regarding grandfathered health plans may be directed to HMSA's Customer Service Center at (808) 948-6372.