



## GENERAL CONTRACTORS ASSOCIATION OF HAWAII

1065 AHUA STREET • HONOLULU, HAWAII 96819-4493 • PHONE 808-833-1681 • FAX 808-839-4167

E-MAIL ADDRESS: [gca@gcahawaii.org](mailto:gca@gcahawaii.org) • WEBSITE: [www.gcahawaii.org](http://www.gcahawaii.org)

June 1, 2011

**Rates effective  
July 1, 2011**

### GCA's MEDICAL PROGRAM COMPANY EXECUTIVES, SUPERVISORY PERSONNEL, OFFICE EMPLOYEES and OTHER NON-UNION PERSONNEL

#### **\*\* GCA MEMBERS \*\***

**Note:** These Plans meet the requirements of the State of Hawaii Law that require you to make a hospital, surgical, and medical care plan available to your employees.

#### ◆ **BACKGROUND**

The GCA's Medical Plans for **Non-Bargaining Unit Employees** were developed so that companies could provide their supervisory personnel, office employees, and other non-union employees with health and welfare plans that are comparable to the plans covering their unionized employees.

#### ◆ **MEMBERSHIP LIMITED**

Participation in the plan is **limited to GCA Member Companies**.  
No minimum number of employees is required.

#### ◆ **ENROLLMENT PERIOD (June 1-30, 2011 only)**

1. **Current GCA Members** can enroll **ONLY** during the enrollment period.
2. **New members** can enroll at the time they join, regardless of the time of year.
3. The Dental or Drug/Vision Riders can be enrolled in or cancelled **ONLY** during the enrollment period.

#### ◆ **SIGN-UP PROCEDURE**

**Only** if your company is **not** currently covered under GCA's plan, fill out and sign the attached "Application Form" and send it back to the GCA.

If your Company is presently covered by a non-GCA HMSA Plan, HMSA will merely switch you over to our Plan. A sufficient number of brochures will be sent to you for use in announcing the new program to your personnel. If you prefer, an HMSA Service Representative will come to your Company to explain the new benefits and answer any questions you may have regarding the Plan. New HMSA identification cards will also be prepared for distribution to those who will be covered.

If your Company is **not** currently covered by an HMSA Plan, an HMSA Service Representative will call you to explain their procedures, secure enrollment cards, and whatever else is necessary to process enrollment.

**GCA Member Medical Plan**

Effective July 1, 2011

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The GCA offers three "basic" medical plans:

- Preferred Provider Plan
- HPH Plus
- CompMED

Your company must decide whether to offer one, two or all three basic plans. For all medical plan offered, your company must decide whether it also wishes to offer one or both of the following two options:

Option 1: Prescription drug and vision

Option 2: Dental

Any option you choose will automatically apply to all of your employees who are covered under the "Basic" Plan. In other words, if a total of 10 or more of your employees are covered under the "Basic" Plan, you **cannot cover** only 6 or 7 of them under the option arrangement. **It has to be on an all or nothing basis.**

**Listed** below are the different plans offered by GCA. The cost of the basic coverage, as well as optional riders, is listed. Your company must enroll **all** of your **non-bargaining unit employees** in one or more of the GCA plans offered.

**GCA Members that are currently participating in the Association's health care plan and will not be making any changes need not re-apply.**

**FOR MORE INFORMATION**

If you would like more information, or if you have any questions, please call Mary at the GCA Office (#833-1681 ext. 21).

**HMSA CRG PREFERRED PROVIDER PLAN (PPP)**

**(Rates effective July 1, 2011)**

- A. **HMSA "Preferred Provider - Plan 800" (Medical Only)**  
**\$723.30** per month/per employee  
(Covers employee & eligible dependents)
- B. **Option #1: "Preferred Provider - Prescription Drug Plan 515 & Vision Plan AI Rider" (optional)**  
Add **\$140.10** per month/per employee (Drug Plan)  
(Covers employee & eligible dependents)  
  
Add **\$11.72** per month/per employee (Vision Plan)  
(Covers employee & eligible dependents)
- C. **Option #2: "Dental Plan V48/L51" (optional)**  
Add **\$64.74** per month/per employee  
(Covers employee & eligible dependents)

**HMSA CRG COMPMED**

**(Rates effective July 1, 2011)**

- A. **HMSA "Preferred Provider - Plan 801" (Medical Only)**  
\$696.20 per month/per employee  
(Covers employee & eligible dependents)
- B. **Option #1: "Preferred Provider - Prescription Drug Plan 515 & Vision Plan AI Rider" (optional)**  
Add \$140.10 per month/per employee (Drug Plan)  
(Covers employee & eligible dependents)  
  
Add \$11.72 per month/per employee (Vision Plan)  
(Covers employee & eligible dependents)
- C. **Option #2: Dental Plan V48/L51" (optional)**  
Add \$64.74 per month/per employee  
(Covers employee & eligible dependents)

**HMSA CRG HEALTH PLAN HAWAII PLUS (HPH+)**

**(Rates effective July 1, 2011)**

Members have access to the largest HMO network in Hawaii, featuring a wide selection of health centers and hundreds of qualified personal care physicians.

- A. **HMSA "Health Plan Hawaii Plus - Plan (X-B)" (Medical Only)**  
\$701.20 per month/per employee  
(Covers employee & eligible dependents)
- B. **Option #1: "Health Plan Hawaii Plus - Prescription Drug Plan 516 & Vision Plan CK Rider" (optional)**  
Add \$107.60 per month/per employee (Drug Plan)  
(Covers employee & eligible dependents)  
  
Add \$7.40 per month/per employee (Vision Plan)  
(Covers employee & eligible dependents)
- C. **Option #2: "Dental Plan V48/L51" (optional)**  
Add \$64.74 per month/per employee  
(Covers employee & eligible dependents)

**FOR FURTHER INFORMATION REGARDING ANY OF THE MEDICAL CARE PLANS,  
PLEASE CONTACT MR. NORMAN NONAKA OF HMSA'S GROUP ADMINISTRATION & MARKETING**

**OFFICE**

**☎ #948-5607 ☎**



# 2011 Choice Medical with Drug, Vision & Dental

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## ***BENEFIT PLAN COMPARISON – effective July 1, 2011***

*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.*



*Working for a Healthier Hawaii*

## 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](https://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.

This carryover provision does not apply to dental.

**Note: Asterisk \* = Indicates annual deductible applies.**

PLAN PROVISIONS	PREFERRED PROVIDER PLAN 2010 (800)		COMPME – 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)		COMPME – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
<b>PHYSICIAN SERVICES</b>					
Office Visits	\$12 <sup>(1)</sup>	30%*	\$14 <sup>(1)</sup>	\$14 <sup>(1)</sup>	\$15
Hospital Visits	\$12 <sup>(1)</sup>	30%*	\$20 <sup>(1)</sup>	\$20 <sup>(1)</sup>	\$15 (hospital outpatient) None (hospital inpatient)
Emergency Room	\$12 <sup>(1)</sup>	\$12 <sup>(1)</sup>	\$20 <sup>(1)</sup>	\$20 <sup>(1)</sup>	None
<b>HOSPITAL AND FACILITY SERVICES</b>					
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 <sup>(1)</sup>	\$75 <sup>(1)</sup>	\$100 <sup>(1)</sup>	\$100 <sup>(1)</sup>	\$75
<b>SURGICAL SERVICES</b>					
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)
<b>LABORATORY AND RADIOLOGY</b>					
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)

<sup>(1)</sup> This amount does not include tax.

MEDICAL SERVICES	PREFERRED PROVIDER PLAN 2010 (800)		COMPAMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
<b>OTHER MEDICAL SERVICES</b>					
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 <sup>(2)</sup>	Not covered	None <sup>(3)</sup>	None <sup>(3)</sup>	\$15 (office visit) <sup>(2)</sup> \$15 (hospital outpatient) <sup>(2)</sup> None (hospital inpatient) <sup>(2)</sup>
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)		COMPAMED – A (801)		HEALTH PLAN HAWAII PLUS (XB)
	YOUR COPAYMENT		YOUR COPAYMENT		YOUR COPAYMENT
	Participating Providers	Nonparticipating Providers	Participating Providers	Nonparticipating Providers	In-Network
<b>BENEFITS FOR CHILDREN</b>					
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
<b>BENEFITS FOR MEN</b>					
Prostate Specific Antigen (PSA) Test (screening)	20%	30%*	None	None	Regular Plan Benefits
Vasectomy	10%	30%*	20%	20%	Regular Plan Benefits
<b>BENEFITS FOR WOMEN</b>					
<b>Contraceptives<sup>(4)</sup></b>					
Implants	50%	50%	20%	20%	50%
IUD	50%	50%	20%	20%	50%
Injectables	50%	50%	20%	20%	50% <sup>(5)</sup>
Mammography (screening)	None	30%	None	None	None
Pap Smears (screening)	None	30%*	None	None	None
Maternity Care	Regular Plan Benefits	Regular Plan Benefits	10%	10%	Regular Plan Benefits
			(Includes facility & inpatient ancillary services)		
Well Woman Exam	None	30%*	None	None	None

<sup>(2)</sup> 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.

<sup>(3)</sup> 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.

<sup>(4)</sup> Copayments will not count towards the annual copayment maximum.

<sup>(5)</sup> A separate copayment may be charged for administration of the injection.

SPECIAL BENEFITS	PREFERRED PROVIDER PLAN 2010 (800)		COMPAMED – 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 <sup>(6)</sup>	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 <a href="http://www.hmsa.com">www.hmsa.com</a> . 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 <u>free</u> 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.				
<b>HMSA'S CARE CONNECTION</b>					
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				
<sup>(6)</sup> U.S. Preventive Services Task Force Recommended Grade A & B Screenings					
<b>FOR DIABETIC SUPPLIES, INSULIN AND ADDITIONAL CONTRACEPTIVES PLEASE REFER TO YOUR DRUG SECTION</b>					

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

<b>GENERIC<sup>(11)</sup></b>	\$11	Not covered	\$11	Not covered
<b>PREFERRED BRAND NAME</b>	\$65	Not covered	\$65	Not covered
<b>OTHER BRAND NAME</b>	\$65 plus \$135 <sup>(12)</sup> Other Brand Name cost share	Not covered	\$65 plus \$135 <sup>(12)</sup> Other Brand Name cost share	Not covered
<b>SPECIALTY DRUGS</b>	Not covered	Not covered	Not covered	Not covered
<b>U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS<sup>(9)</sup></b>	None	Not covered	None	Not covered
<b>ORAL CHEMOTHERAPY DRUGS</b>	None	Not covered	None	Not covered
<b>INSULIN</b>				
Preferred Brand Name	\$11	Not covered	\$11	Not covered
Other Brand Name	\$65	Not covered	\$65	Not covered
<b>DIABETIC SUPPLIES</b>				
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.

<sup>(7)</sup> See Additional Benefits section for Contraceptive Diaphragms.

<sup>(8)</sup> Benefit available at Par Specialty Pharmacies only

<sup>(9)</sup> USPSTF A & B Recommendations

<sup>(10)</sup> Limited to the items on HMSA's SELECT formulary

<sup>(11)</sup> Includes Single Source Generic Drugs

<sup>(12)</sup> \$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
<b>EYE EXAMINATION</b> One per calendar year	\$10 annual deductible	All charges less \$40 plan payment	Refer to Medical Plan for Examination Benefits	Not covered
<b>LENSES</b> (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
<b>ADDITIONAL BENEFITS</b>				
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
<b>FRAMES</b> 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.

<b>DENTAL CARE SERVICES</b>	<b>PARTICIPATING PROVIDER PROGRAM (V48)</b>	<b>DENTAL NETWORK PROGRAM (L51)</b>
<b>PROVISIONS</b>	<b>Refer to Dental Guide to Benefits for benefit and age limitations.</b>	
Calendar Year Maximum	\$1,000	None
Calendar Year Rollover	Accumulate up to \$1,000 <sup>(13)</sup>	Not Applicable
Choice of Dentists	HMSA Participating Provider Network (Par) or any licensed Dentist (Non-Par)	HMSA Dental Network Providers Hawaii Family Dental Centers (statewide)
<b>PREVENTIVE CARE</b>	<b>YOUR COPAYMENT</b>	<b>YOUR COPAYMENT</b>
Exams	None	None
	Two per calendar year	Two per calendar year
Cleaning	None	None
	Two per calendar year	Two per calendar year
Topical Fluoride	None	None
	Two per calendar year; age 18 and under	Two per calendar year; age 18 and under
X-rays	None	None
	One set of bitewings per calendar year and one full mouth x-ray every 3 years	One set of bitewings per calendar year and one full mouth x-ray every 3 years
<b>ROUTINE CARE</b>		
X-Rays - Periapical	30% No Limitation	None No Limitation
Fillings	30%	\$10 per tooth for amalgam; \$15 per tooth for composite resin restorations (anterior teeth and single, stand alone, facial surface of bicuspsids only)
Sealants on permanent molars	30%	None
	One per lifetime; age 16 and under	One per lifetime; age 16 and under
Space Maintainers	30%	\$25 per procedure
	Age 13 and under	Age 13 and under
Endodontics	30%	\$15 per tooth for pulpotomy; \$50 per tooth for root canal therapy
Periodontics	30%	\$75 for gingivectomy or gingivoplasty for 4 or more contiguous teeth; \$10 for 1 to 3 contiguous teeth
<b>MAJOR CARE</b>		
Waiting Period – New Members	12 Months for Bridges, Dentures, Implants & Crowns	12 Months for Bridges, Dentures & Crowns
Crowns, Bridges	30%	\$100 high noble metal
Dentures		
Partial upper or lower denture	30%	\$150 per denture
Complete upper or lower denture	30%	\$175 per denture
Endosteal Implants	30%	Not a Benefit
Orthodontics	Not a Benefit	Special member rates

<sup>(13)</sup> Rollover Amount is up to \$350 per year if at least one dental service is received and benefits paid in the prior calendar year do not exceed \$500.