

NON-MEDICARE RETIREES

Medical Plan Coverage Chart (HMSA and Kaiser) - EUTF

This summary chart is intended to provide a condensed summary of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from the EUTF website at eutf.hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN			
Benefits will be administered as described in each plan's documents.			
Plan Provisions	HMSA PPO		Kaiser HMO
General			
Calendar Year Deductible Single/Family	\$100 per person Maximum \$300 per family		None/None
Calendar Year Out-of-pocket limit Single/Family	\$2,500 per person Maximum \$7,500 per family		\$2,000 per person Maximum \$6,000 per family
Lifetime Benefit Maximum	None		None
	Your Copayment		
	In-Network	Out-of-Network	
Physician Services			
Primary Care Office Visit	10% *	30%	\$15
Specialist Office Visit	10% *	30%	\$15
Routine physical exams	Not Covered	Not Covered	No Charge
Mammography	20% *	30% *	No Charge
Second opinion – surgery	10% *	30%	\$15
Emergency Room (ER care)	10% *	10% *	\$50 in area / 20% out
Ambulance	20%	30%	20%
Inpatient Hospital Services			
Room & Board	10% *	30%	No Charge
Ancillary Services	10% *	30%	No Charge
Physician services	10% *	30%	No Charge
Surgery	10% *	30%	No Charge
Anesthesia	10% *	30%	No Charge
Outpatient Services			
Chemotherapy	20%	30%	\$15
Radiation Therapy	20% *	30%	\$15
Surgery	10%* (Cutting)	30%	\$15
Allergy Testing	20%	30%	\$15
Other Diag. Lab, X-ray & Psych Testing	20% *	30%	\$15
Anesthesia	10% *	30%	No Charge; \$15 office visit copay applies
Mental Health Services			
Inpatient care	10% *	30%	No Charge
Outpatient Care	10% *	30%	\$15
Other Services			
Durable Medical Equipment	20%	30%	20%
Home Health care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge
Nursing facility - skilled care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
Physical & Occupational Therapy	20%	30%	\$15

*Deductible does not apply.