HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Option Plus *two*

Medical Plan Schedule of Benefits

Annual Deductible $100 per person / $300 maximum per family

Stop Loss $2,500 per person / $7,500 per family (per calendar year, includes deductibles & copayments)

Lifetime Maximum Unlimited

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	10%	30%*
Hospital Ancillary Services	10%	30%*
Hospital Room and Board	10%	30%*
Outpatient Facility	10%	30%*
Skilled Nursing Facility	10%	30%*
Emergency Services		
Emergency Room	10%	10%
Physician Visits	10%	10%
Online Care and Telephonic Services	None	Not Covered
Physician Services		
Physician Visits	10%	30%*
Hospital Visits	10%	30%*
Immunizations (standard, including travel)	None	30%*
Testing, Laboratory and Radiology		
Allergy Testing	20%*	30%*
Allergy Treatment Materials	20%*	30%*
Diagnostic Testing — Inpatient	10%	30%*
Outpatient	20%	30%*
Laboratory and Pathology — Inpatient	10%	30%*
Outpatient	20%	30%*
Radiology — Inpatient	10%	30%*
Outpatient	20%	30%*
Chemotherapy and Radiation Therapy		
Chemotherapy — Infusion/Injections	20%*	30%*
Radiation Therapy — Inpatient	10%	30%*
Outpatient	20%	30%*
Other Medical Services and Supplies		
Acupuncture, Chiropractic, Naturopathic Services	10%	30%*
Ambulance (air)	20%*	30%*
Ambulance (ground)	20%*	30%*
Blood and Blood Products	20%*	30%*
Dialysis and Supplies	20%*	30%*
Durable Medical Equipment & Supplies	20%*	30%*
Evaluations for Hearing Aids	20%	30%*
Growth Hormone Therapy	20%*	30%*
Home IV Therapy	None	30%*
Inhalation Therapy	20%*	30%*
Injections	20%*	30%*
Medical Foods	20%	30%
Orthotics and External Prosthetics	20%*	30%*
Vision and Hearing Appliances	20%*	30%*

* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

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Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Rehabilitation Therapy		
Physical and Occupational Therapy		
Inpatient	10%	30%*
Outpatient	20%*	30%*
Speech Therapy Services — Inpatient	10%	30%*
Outpatient	20%*	30%*
Special Benefits – Disease Management and Preventive Services		
Disease Management	None	Not covered
Preventive Services — Laboratory	None	30%*
Preventive Services — Physical Exam	None	30%*
Screening and Preventive Counseling	None	30%*
Special Benefits for Children		
Newborn Care	10%	30%*
Well Child Care Immunizations	None	None
Well Child Care Laboratory Tests	None	30%
Well Child Care Physician Office Visits	None	30%
Special Benefits for Men		
Prostate Specific Antigen Test (screening)	20%	30%*
Special Benefits for Women		
Breast Pump	None	None*
Chlamydia Screening	None	30%*
Contraceptive Implants (generic)	None	30%
Contraceptive Injectables (generic)	None	30%
Contraceptive IUD (generic)	None	30%
In Vitro Fertilization	10%	30%
Mammography (screening)	None	30%
Maternity Care	10%	30%*
Pap Smears (screening)	None	30%*
Pregnancy Termination	10%	30%*
Tubal Ligation	None	30%*
Well Woman Exam	None	30%*
Special Benefits for Homebound, Terminal, or Long-Term Care		
Home Health Care	None	30%*
Hospice Services	None	Not covered
Behavioral Health – Mental Health and Substance Abuse		
Hospital and Facility Services	10%	30%*
Physician Services	10%	30%*
Psychological Testing — Inpatient	10%	30%*
Outpatient	20%	30%*
Special Offers		
Employee Assistance Program (EAP)	Up to 6 fully-covered visits to assist subscribers with personal or family issues	
Health and Wellness Programs	A variety of solutions for healthy living including Active&Fit®, Flu Prevention, Colorectal Cancer Screening, Maternity & Baby Care Incentive Program, and more	
Member Plus Discount Program	Discounted prices and special offers from HMAA member groups and other participating merchants	

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* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

Note: Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods. This document is intended to provide a condensed explanation of benefits. Please refer to the Description of Coverage (DOC) for details. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.