

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
FORM HC-16: APPLICATION FOR REIMBURSEMENT-TYPE PLAN APPROVAL

SECTION 1: GENERAL PLAN INFORMATION

EMPLOYER NAME:
PLAN NAME:
HAWAII DEPARTMENT OF LABOR (DOL) ACCOUNT NUMBER:

PLAN DETAILS

CONTRACTOR/INSURER NAME:
NAME OF PROVIDER NETWORK IN HAWAII:
DATE SUBMITTED:
REQUESTED EFFECTIVE DATE OF APPROVAL:
*Plan will not be approved retroactively. Submitting an employer-sponsored plan does not relieve the employer of the responsibility to provide an approved plan.
IS THIS A PREVIOUSLY APPROVED PLAN THAT IS BEING AMENDED?
<input type="checkbox"/> NO <input type="checkbox"/> YES *If yes, please list all changes in Section 4.
UNDER WHICH SECTION ARE YOU SEEKING APPROVAL? <input type="checkbox"/> 393-7(a), HR <input type="checkbox"/> 393-7(b), HRS

SECTION 2: CERTIFICATION

I DECLARE UNDER PENALTY OF LAW THAT ALL THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

NAME:	TITLE:
PHONE NUMBER:	EMAIL ADDRESS:

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individual with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9188

SECTION 3: PLAN PROVISIONS COMPARISON

PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
1. ELIGIBILITY REQUIREMENT	Hawaii employee working 20 or more hours per week for 4 consecutive weeks.		
2. LATE ENROLLMENT	If loss of coverage is due to a termination of Form HC-5, employee can enroll outside the open-enrollment period.		
3. ANNUAL DEDUCTIBLE	\$100/person \$300/family		
4. PLAN YEAR	Calendar year		
5. LIFETIME BENEFITS MAXIMUM	None		
6. ANNUAL OUT-OF-POCKET MAXIMUM	\$2,500 per individual including deductible & copayments. Family: up to 3 times individual.		
7. PREEXISTING CONDITION LIMITATION	None		

HOSPITAL BENEFITS * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
8. HOSPITAL ROOM & BOARD	90% PPO 70%* NPO		
9. REGULAR & SPECIAL DIETS	90% PPO 70%* NPO		
10. GENERAL NURSING SERVICES	90% PPO 70%* NPO		
11. OPERATING ROOM & SURGICAL SUPPLIES	90% PPO 70%* NPO		
12. ANESTHESIA SERVICES & SUPPLIES	90% PPO 70%* NPO		
13. DRUGS, DRESSINGS, OXYGEN, ANTIBIOTICS, BLOOD TRANSFUSION SERVICES	90% PPO 70%* NPO		
14. PRE-ADMISSION CERTIFICATION REQUIREMENT	None. If condition requires inpatient care, inpatient review of records takes place after admission.		
15. PRE-ADMISSION PENALTY	None		

OUTPATIENT CARE * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
16. OUTPATIENT HOSPITAL	90% PPO 70%* NPO		
17. EMERGENCY ROOM	80%		

SURGICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
18. PHYSICIAN SURGICAL SERVICES	90% PPO 70%* NPO		
19. AFTER-CARE VISITS	90% PPO 70%* NPO		
20. ANESTHESIOLOGIST SERVICES	90% PPO 70%* NPO		

MEDICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
21. PHYSICIAN HOME, OFFICE & HOSPITAL VISIT	90% PPO 70%* NPO		
22. PHYSICIAN EMERGENCY ROOM VISITS	90%		
23. URGENT CARE	90% PPO 70%* NPO		
24. SPECIALIST PHYSICIAN HOME & OFFICE VISITS	90% PPO 70%* NPO		
25. INTENSIVE MEDICAL CARE WHILE HOSPITALIZED	90% PPO 70%* NPO		
26. MEDICAL/SURGICAL CONSULTATION WHILE CONFINED	90% PPO 70%* NPO		
27. LAB/PATH OUTPATIENT	80% PPO 70%* NPO		
28. LAB/PATH INPATIENT	90% PPO 70%* NPO		

MEDICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
29. RADIOLOGY-OUTPATIENT	80% PPO 70%* NPO		
30. RADIOLOGY-INPATIENT	90% PPO 70%* NPO		
31. RADIOLOGY- ADVANCED IMAGING	80% PPO 70%* NPO		
32. RADIOTHERAPEUTIC SERVICES OUTPATIENT	80% PPO 70%* NPO		
33. RADIOTHERAPEUTIC SERVICES INPATIENT	90% PPO 70%* NPO		
34. MATERNITY	100% PPO 70%* NPO		

MENTAL HEALTH AND SUBSTANCE ABUSE * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
35. HOSPITAL & FACILITY SERVICES OUTPATIENT	90% PPO 70%* NPO		
36. HOSPITAL & FACILITY SERVICES INPATIENT	90% PPO 70%* NPO		
37. PHYSICIAN SERVICES OUTPATIENT	90% PPO 70%* NPO		
38. PHYSICIAN SERVICES INPATIENT	90% PPO 70%* NPO		

OTHER * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
38. AMBULANCE-AIR	80%*		
39. AMBULANCE-GROUND	80%* PPO 70%* NPO		
40. SCREENING MAMMOGRAM	100% PPO 70%* NPO		
41. CHEMOTHERAPY	80%* PPO 70%* NPO		
42. DURABLE MEDICAL EQUIPMENT	80%* PPO 70%* NPO		
43. HOME HEALTH CARE	100% PPO 70%* NPO 150 VISITS/YEAR		
44. HOSPICE CARE	100% PPO NOT COVERED NPO		
45. IN-VITRO FERTILIZATION	Deductible/copay depend on type of service/supply. 1 per PPO, may be entitled to an additional IVF if IVF was not received under existing group		
46. MEDICAL FOODS	80%		
47. PHYSICAL THERAPY OUTPATIENT	80%* PPO 70%* NPO		
48. PHYSICAL THERAPY INPATIENT	90% PPO 70%* NPO		
49. SPEECH THERAPY OUTPATIENT	80%* PPO 70%* NPO		

OTHER * INDICATES DEDUCTIBLE APPLIES			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
50. SPEECH THERAPY INPATIENT	90% PPO 70%* NPO		
51. OCCUPATIONAL THERAPY OUTPATIENT	80%* PPO 70%* NPO		
52. OCCUPATIONAL THERAPY INPATIENT	90% PPO 70%* NPO		
53. PREGNANCY TERMINATION	90% PPO 70%* NPO		
54. SKILLED NURSING FACILITY	90% PPO 70%* NPO 120 DAYS PER PLAN YEAR		
55. TRANSPLANT: CORNEAL OR KIDNEY	90% PPO 70%* NPO		
56. TRANSPLANT: BONE MARROW, HEART, HEART/LUNG, LIVER, LUNG, PANCREAS, KIDNEY/PANCREAS, SMALL BOWEL AND MULTIVISCERAL, STEM CELL	Approved or contracted providers only. 100%		
57. WELL CARE VISITS- ADULT	100% PPO 70%* NPO		
58. WELL CARE VISITS- CHILD	100% PPO 70% NPO		

ADDITIONAL BENEFITS, IF ANY; OTHERWISE, ENTER "NONE"			
PROVISIONS	7(a) HMSA PREFERRED PROVIDER PLAN (PREVALENT PPO PLAN)	EXPLAIN HOW THE PLAN'S PROVISION, BENEFIT, LIMIT & OTHER PERTINENT INFO DIFFER FROM THE 7(a) COLUMN; OTHERWISE ENTER "SAME".	LOCATION IN FILING (PAGE #)
59. VISION, DENTAL, PRESCRIBED DRUG OR OTHER CATEGORIES OF BENEFITS			

EXCLUSIONS		
60. INDICATE THE LOCATION OF EXCLUSIONS IN THE PLAN		

DEFINITIONS		
61. INDICATE THE LOCATION OF DEFINITIONS IN THE PLAN		

**SECTION 4: CHANGES MADE TO PREVIOUSLY APPROVED PLAN
(ATTACH ADDITIONAL PAGES AS NEEDED.)**

LIST TYPE OF CHANGE: - BENEFIT - LANGUAGE - OTHER (CORRECT TYPO, ETC.)	SUMMARIZE THE CHANGE BEING REQUESTED:	SECTION(S) AFFECTED	LOCATION IN FILING (PAGE #)