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? ☐ NO ☐ YES *If yes, please list all changes in Section 4.
UNDER WHICH SECTION ARE YOU SEEKING APPROVAL? ☐ 393-7(a), HRS ☐ 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:

SECTION 3: PLAN PROVISIONS COMPARISON

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 #)	OFFICE USE ONLY
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) 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 #)**	**OFFICE USE ONLY**
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 #)**	**OFFICE USE ONLY**
16. OUTPATIENT HOSPITAL	90% PPO 70%* NPO			
17. EMERGENCY ROOM	80%			

SURGICAL BENEFITS * 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 #)**	**OFFICE USE ONLY**
18. PHYSICIAN SURGICAL SERVICES -CUTTING SURGERY	90% PPO 70%* NPO			
19. PHYSICIAN SURGICAL SERVICES -NON CUTTING SURGERY	80% PPO 70%* NPO			
20. AFTER-CARE VISITS	90% PPO 70%* NPO			
21. ANESTHESIOLOGIST SERVICES	90% PPO 70%* NPO			

MEDICAL BENEFITS * 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 #)**	**OFFICE USE ONLY**
22. PHYSICIAN HOME, OFFICE & HOSPITAL VISIT	90% PPO 70%* NPO			
23. PHYSICIAN EMERGENCY ROOM VISITS	90%			
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) 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 #)**	**OFFICE USE ONLY**
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	90% PPO 70%* NPO			

MENTAL HEALTH AND SUBSTANCE ABUSE *** 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 #)**	**OFFICE USE ONLY**
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) 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 #)**	**OFFICE USE ONLY**
39. AMBULANCE	80%* (AIR) 80%* PPO (GROUND) 70%* NPO (GROUND)			
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			
50. SPEECH THERAPY INPATIENT	90% PPO 70%* NPO			

OTHER *** 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 #)**	**OFFICE USE ONLY**
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. URGENT CARE	90% PPO 70%* NPO			
58. WELL CARE VISITS-ADULT	100% PPO 70%* NPO			
59. WELL CARE VISITS-CHILD	100% PPO 70% NPO			

ADDITIONAL BENEFITS, IF ANY; OTHERWISE, ENTER "NONE"				
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 #)**	**OFFICE USE ONLY**
60. VISION, DENTAL, PRESCRIBED DRUG OR OTHER CATEGORIES OF BENEFITS				

EXCLUSIONS			
61. INDICATE THE LOCATION OF EXCLUSIONS IN THE PLAN			

DEFINITIONS			
62. 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 #)	OFFICE USE ONLY