STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

# FORM HC-17: APPLICATION FOR SERVICE-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:<br><br>*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?<br>☐ NO ☐ YES *If yes, please list all changes in Section 4. |
| UNDER WHICH SECTION ARE YOU SEEKING APPROVAL?<br>☐ 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: |

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) KPG Plan (PREVALENT HMO 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 | None | | |
| 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) KPG Plan (PREVALENT HMO 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 | 80% | | |
| 9. REGULAR & SPECIAL DIETS | 80% | | |
| 10. GENERAL NURSING SERVICES | 80% | | |
| 11. OPERATING ROOM & SURGICAL SUPPLIES | 80% | | |
| 12. ANESTHESIA SERVICES & SUPPLIES | 80% | | |
| 13. DRUGS, DRESSINGS, OXYGEN, ANTIBIOTICS, BLOOD TRANSFUSION SERVICES | 80% | | |
| 14. PRE-ADMISSION CERTIFICATION REQUIREMENT | Non-urgent care must be arranged by PCP at HMO facility; pre-auth required for post-stabilization care from non-HMO provider/facility. | | |
| 15. PRE-ADMISSION PENALTY | | | |

| OUTPATIENT CARE * INDICATES DEDUCTIBLE APPLIES | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 | 80% | | |
| 17. EMERGENCY ROOM | 80% | | |

| SURGICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 | 80% | | |
| 19. AFTER-CARE VISITS | $20/visit | | |
| 20. ANESTHESIOLOGIST SERVICES | 80% | | |

| MEDICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 | $20/visit | | |
| 22. PHYSICIAN EMERGENCY ROOM VISITS | 80% | | |
| 23. URGENT CARE | $20/visit<br>80% if outside service area. | | |
| 24. SPECIALIST PHYSICIAN HOME & OFFICE VISITS | $20/visit | | |
| 25. INTENSIVE MEDICAL CARE WHILE HOSPITALIZED | 80% | | |
| 26. MEDICAL/SURGICAL CONSULTATION WHILE CONFINED | 80% | | |
| 27. LAB/PATH OUTPATIENT | $20/day | | |
| 28. LAB/PATH INPATIENT | 80% | | |

| MEDICAL BENEFITS * INDICATES DEDUCTIBLE APPLIES | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 | $20/day | | |
| 30. RADIOLOGY- INPATIENT | 80% | | |
| 31. RADIOLOGY- ADVANCED IMAGING | 80% | | |
| 32. RADIOTHERAPEUTIC SERVICES OUTPATIENT | 80% | | |
| 33. RADIOTHERAPEUTIC SERVICES INPATIENT | 80% | | |
| 34. MATERNITY | 80% | | |

| MENTAL HEALTH AND SUBSTANCE ABUSE * INDICATES DEDUCTIBLE APPLIES | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 | $20/visit | | |
| 36. HOSPITAL & FACILITY SERVICES INPATIENT | 80% | | |
| 37. PHYSICIAN SERVICES OUTPATIENT | $20/visit | | |
| 38. PHYSICIAN SERVICES INPATIENT | 80% | | |

| **OTHER** *** INDICATES DEDUCTIBLE APPLIES** | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 #)** |
| 39. AMBULANCE - AIR | 80% | | |
| 40. AMBULANCE – GROUND | 80% | | |
| 41. NON-EMERGENCY MEDICAL TRANSPORTATION | 100% | | |
| 42. SCREENING MAMMOGRAM | 100% | | |
| 43. CHEMOTHERAPY | $20/visit or 80% | | |
| 44. DURABLE MEDICAL EQUIPMENT | 80% | | |
| 45. HOME HEALTH CARE | 100% | | |
| 46. HOSPICE CARE | 100% | | |
| 47. IN-VITRO FERTILIZATION | 80%<br>1 attempt/lifetime | | |
| 48. MEDICAL FOODS | 80% | | |
| 49. PHYSCIAL THERAPY OUTPATIENT | $20/visit | | |
| 50. PHYSICAL THERAPY INPATIENT | 80% | | |
| 51. SPEECH THERAPY OUTPATIENT | $20/visit | | |

| **OTHER * INDICATES DEDUCTIBLE APPLIES** | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 #)** |
| 52. SPEECH THERAPY INPATIENT | 80% | | |
| 53. OCCUPATIONAL THERAPY OUTPATIENT | $20/visit | | |
| 54. OCCUPATIONAL THERAPY INPATIENT | 80% | | |
| 55. PREGNANCY TERMINATION | $20/visit or 80% | | |
| 56. SKILLED NURSING FACILITY | 80%<br>120 days per Accumulation Period | | |
| 57. TRANSPLANT: CORNEAL OR KIDNEY | $20/visit or 80% | | |
| 58. TRANSPLANT: BONE MARROW, HEART, HEART/LUNG, LIVER, LUNG, PANCREAS, KIDNEY/PANCREAS, SMALL BOWEL, SMALL BOWEL/LIVER, SMALL BOWEL AND MULTIVISCERAL, STEM CELL | 80% | | |
| 59. WELL CARE VISITS-ADULT | 1 annual visit @ 100% then $20/visit | | |
| 60. WELL CARE VISITS-CHILD | 100% | | |

| ADDITIONAL BENEFITS, IF ANY; OTHERWISE, ENTER "NONE" | | | |
|---|---|---|---|
| **PROVISIONS** | **7(a) KPG Plan (PREVALENT HMO 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 #)** |
| 61. VISION, DENTAL, PRESCRIBED DRUG OR OTHER CATEGORIES OF BENEFITS | | | |

| EXCLUSIONS | | |
|---|---|---|
| 62. INDICATE THE LOCATION OF EXCLUSIONS IN THE PLAN | | |

| DEFINITIONS | | |
|---|---|---|
| 63. 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:<br>- BENEFIT<br>- LANGUAGE<br>- OTHER (CORRECT TYPO, ETC.) | SUMMARIZE THE CHANGE BEING REQUESTED: | SECTION(S) AFFECTED | LOCATION IN FILING (PAGE #) |
|---|---|---|---|
| | | | |