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: *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) 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 #)	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	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 #)**	**OFFICE USE ONLY**
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	Nonurgent 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 #)**	**OFFICE USE ONLY**
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 #)**	**OFFICE USE ONLY**
18. PHYSICIAN SURGICAL SERVICES-CUTTING SURGERY	80%			
19. PHYSICIAN SURGICAL SERVICES-NON CUTTING SURGERY	80%			
20. AFTER-CARE VISITS	$20/visit			
21. 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 #)**	**OFFICE USE ONLY**
22. PHYSICIAN HOME, OFFICE & HOSPITAL VISIT	$20/visit			
23. PHYSICIAN EMERGENCY ROOM VISITS	80%			
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%			
29. RADIOLOGY-OUTPATIENT	$20/day			

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 #)**	**OFFICE USE ONLY**
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 #)**	**OFFICE USE ONLY**
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 #)**	**OFFICE USE ONLY**
39. AMBULANCE	80%			
40. SCREENING MAMMOGRAM	100%			
41. CHEMOTHERAPY	$20/visit or 80%			
42. DURABLE MEDICAL EQUIPMENT	80%			
43. HOME HEALTH CARE	100%			
44. HOSPICE CARE	100%			
45. IN-VITRO FERTILIZATION	80% 1 attempt/lifetime			
46. MEDICAL FOODS	80%			
47. PHYSCIAL THERAPY OUTPATIENT	$20/visit			
48. PHYSICAL THERAPY INPATIENT	80%			
49. SPEECH THERAPY OUTPATIENT	$20/visit			
50. SPEECH THERAPY 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 #)**	**OFFICE USE ONLY**
51. OCCUPATIONAL THERAPY OUTPATIENT	$20/visit			
52. OCCUPATIONAL THERAPY INPATIENT	80%			
53. PREGNANCY TERMINATION	$20/visit or 80%			
54. SKILLED NURSING FACILITY	80% 120 days per Accumulation Period			
55. TRANSPLANT: CORNEAL OR KIDNEY	$20/visit or 80%			
56. TRANSPLANT: BONE MARROW, HEART, HEART/LUNG, LIVER, LUNG, PANCREAS, KIDNEY/PANCREAS, SMALL BOWEL, SMALL BOWEL/LIVER, SMALL BOWEL AND MULTIVISCERAL, STEM CELL	80%			
57. URGENT CARE	$20/visit 80% if outside service area.			
58. WELL CARE VISITS-ADULT	1 annual visit @ 100% then $20/visit			
59. 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 #)**	**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