

# 2005 MAINLAND MEDICAL PLAN COMPARISON CHART

The following charts highlight the major provisions and benefits of each of the medical plans available through *FlexSolutions*, and are not intended to fully describe your coverage. Additional details can be found in A&B's Benefits Handbook, available at [www.flexab.com](http://www.flexab.com).

The percentage amounts shown reflect the amount of eligible charges the Plan(s) will pay for a covered service. You are responsible for paying the remaining percentage and the difference, if any, between the actual charges and the eligible charges.

Note that not all Plans are available at each location; your 2005 Enrollment Worksheet will list those Plans for which you are eligible to enroll.

BENEFIT PROVISIONS	CIGNA PPO PLAN	CIGNA HMO PLAN	KAISER PERMANENTE HMO PLAN
<b>AT A GLANCE</b>			
<i>Provider Choice/ How the Plan Works</i>	Individuals may visit any qualified provider; however, the Plan pays higher benefits when a "network" provider is used.	Individuals must use network providers and/or have their care coordinated by their Primary Care Physician (PCP). No benefits are paid for non-approved care.	Individuals must use Kaiser Permanente providers and facilities. No benefits are paid for non-approved out-of-network care, except for emergencies.
<i>Annual Deductible</i>	Network = None; Non-Network = \$250/individual, \$500/family	N/A	N/A
<i>Annual Out-of-Pocket Maximum</i>	Network = \$2,000/individual, \$4,000/family; Non-Network = \$4,000/individual, \$8,000/family	\$1,500/individual; \$3,000/family	\$1,500/individual; \$3,000/family
<i>Lifetime Maximum</i>	Unlimited	Unlimited	Unlimited
<b>AT THE DOCTOR'S OFFICE</b>			
<i>Office Visits</i>	Network = 100% after \$10 copayment Non-Network = 70% after deductible	100% after \$10 copayment (PCP) or \$15 copayment (specialist)	100% after \$10 copayment
<i>Preventive Care</i>	Network = 100% after \$10 copayment for one exam every 12 months Non-Network = not covered	100% after \$10 copayment, benefit limited to one exam/ calendar year	100% after \$10 copayment
<i>Well Child Care</i>	Network = 100% after \$10 copayment up to 10 exams for children through age 5; Non-Network = not covered	100% after \$10 copayment	100% after \$5 copayment for children to age 2
<b>AT THE HOSPITAL</b>			
<i>Emergency Room (for true emergency)</i>	Network and Non-Network = 90%	Emergency Room: 100% after \$50 copayment; Urgent Care Center: 100% after \$35 copayment	100% after \$10 copayment (copayment waived if hospitalized)
<i>Semi-Private Room and Board</i>	Network = 90%; Non-Network = 70% after annual deductible and \$200 hospital confinement deductible	100%	100%
<i>Inpatient X-ray and Lab Services</i>	Network = 90% Non-Network = 70% after the deductible	100%	100%
<b>SURGERY</b>			
<i>Outpatient</i>	Network = 90%; Non-Network = 70% after deductible	100%	100% after a \$10 copayment
<i>Inpatient</i>	Network = 90%; Non-Network = 70% after deductible	100%	100%
<b>MATERNITY AND FAMILY PLANNING SERVICES</b>			
<i>Office Visits</i>	Network = 100% after \$10 copayment for initial visit, 90% thereafter Non-Network = 70% after deductible	100% after \$10 copayment (copayment waived after initial visit)	100% after \$5 copayment
<i>Hospital Services</i>	Network = 90%; Non-Network = 70% after deductible and \$200 hospital confinement deductible	100%	100%
<b>MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT<sup>1</sup></b>			
<i>Inpatient</i>	Network = 90% Non-Network = 70% after deductible; 30 days per calendar year (combined network and non-network)	100% 30 days per calendar year	100%, benefits limited to 45 days/calendar year
<i>Outpatient</i>	Network = 100% after \$10 copayment; Non-Network = 70% after deductible; 35 visits per calendar year (combined network and non-network); two group therapy sessions equal one individual session	100% after \$15 copayment 35 visits per calendar year	100% after \$10/visit, benefits limited to 20 visits per calendar year
<b>OTHER SERVICES</b>			
<i>Prescription Drugs – Retail</i>	Participating pharmacies = You pay \$10 for generics; for brand names you pay \$20 plus the difference between the cost of brand name and generic unless a physician specifies "dispense as written." Non-participating pharmacies = 60% (note: HMO plan members must use participating pharmacies); up to a 30-day supply		100% after \$10 copayment for generic and brand name drugs; up to a 100-day supply
<i>Prescription Drugs – Mail Order</i>	Participating pharmacies only = You pay \$10 for generics; for brand names you pay \$40 plus the difference between the cost of brand name and generic unless a physician specifies "dispense as written," up to a 90-day supply		100% after \$10 copayment for generic and brand name drugs; up to a 100-day supply
<i>X-ray &amp; Lab Services</i>	Network = 90% Non-Network = 70% after deductible	100%	100%
<i>Skilled Nursing Facility</i>	Network = 90% Non-Network = 70% after deductible Benefits limited to 120 days per calendar year	100%	100%; benefits limited to 100 days per calendar year (or benefit period in Southern CA)
<i>Home Health Care</i>	Network = 90% Non-Network = 70% after deductible	100%	100%; up to 100 two-hour visits per calendar year
<i>Hearing Exams/Hearing Aids</i>	Network = 90% Non-Network = 70% after deductible Up to \$1,500/36 months	100% up to \$1,500/36 months	Hearing exams covered at 100% after \$10 copayment; hearing devices covered at 100% up to \$2,500 per device per ear; two devices every 24 months (Northern CA) and every 36 months (Southern CA)
<i>Durable Medical Equipment</i>	Network = 90% Non-Network = 70% after deductible	100%	100%

<sup>1</sup>Under the Kaiser Permanente HMO, severe mental illnesses of any age and severe emotional disturbances of a child are covered the same as any other covered disability in accordance with California state law governing insured health care plans.

# 2005 HAWAII MEDICAL PLAN COMPARISON CHART

BENEFIT PROVISIONS	HMSA PREFERRED PROVIDER PLAN (PPO PLAN)		HMSA HEALTH PLAN HAWAII PLUS HMO PLAN	HMSA HEALTHLINK PLAN			KAISER PERMANENTE HMO PLAN
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS		HEALTHLINK NETWORK PROVIDERS	NON-NETWORK PARTICIPATING PROVIDERS	NON-NETWORK NON-PARTICIPATING PROVIDERS	
<b>AT A GLANCE</b>							
<i>Provider Choice / How the Plan Works</i>	Individuals may visit any qualified provider; however, the Plan pays higher benefits when a participating provider is used. Participants are encouraged to select a Primary Care Physician (PCP) who will coordinate their care.		All services must be provided or arranged by your Primary Care Physician (PCP); no benefits are paid for non-approved out-of-network care.	Individuals must select a Primary Care Physician (PCP); maximum benefits are paid only when network providers are used.			Individuals must use HMO providers; no benefits are paid for non-approved out-of-network care.
<i>Annual Deductible</i>	\$100/individual; \$300/family		None	None	\$200/individual; \$600/family		None
<i>Annual Out-of-Pocket Maximum</i>	\$2,500/individual; \$7,500/family		\$1,500/individual; \$4,500/family	\$750/individual; \$2,250/family	\$2,500/individual		\$1,500/individual; \$4,500/family
<i>Lifetime Maximum</i>	\$2,000,000		Unlimited	Unlimited	\$1,000,000		Unlimited
<b>AT THE DOCTOR'S OFFICE</b>							
<i>Office Visits</i>	90%	70% after annual deductible	100% after \$10 copayment	100% after \$10 copayment	75% after annual deductible	70% after annual deductible	100% after \$12 copayment
<i>Preventive Care</i>	100% for health assessment when services are provided by a HealthPass program provider	Not covered	Physical exams: 100% (\$10 copayment applies for immunizations when not part of an office visit)	Health Pass: 100% (\$10 copayment applies for immunizations when not part of an office visit)	Immunizations only: 75% after annual deductible	Immunizations only: 70% after annual deductible	100% after \$12 copayment
<i>Well Baby / Well Child Care</i>	90% 6 visits/year for children to age 1; 2 visits for age 1 to 2; 1 visit/year for ages 2 through 5	70%	100% through age 5; 100% for standard childhood immunizations	100% through age 5 100% for standard childhood immunizations 6 visits/year for children to age 1; 2 visits for age 1 to 2; 1 visit/year for ages 2 through 5	75% through age 5	70% through age 5	100% after \$12 copayment
<b>AT THE HOSPITAL</b>							
<i>Emergency Room<sup>1</sup></i>	90%	90%	100% after \$25 copayment in Hawaii; 80% outside Hawaii	100% after \$25 copayment in Hawaii; 80% outside Hawaii	70% after annual deductible	70% after annual deductible	100% after \$25 copayment at Kaiser Permanente facilities <sup>2</sup>
<i>Semi-Private Room and Board</i>	90%	70% after annual deductible	100%	90%	70% after annual deductible	70% after annual deductible	100%
<i>Inpatient X-ray and Lab Services</i>	90%	70% after annual deductible	100%	90%	70% after annual deductible	70% after annual deductible	100%
<b>SURGERY</b>							
<i>Outpatient</i>	90% (cutting); 80% (non-cutting)	70% after annual deductible	100% (\$10 copayment applies for physician services)	100% after \$10 copayment	After annual deductible: 75% (cutting); 70% (non-cutting)	70% after annual deductible	100% after \$12 copayment
<i>Inpatient</i>	90% (cutting); 80% (non-cutting)	70% after annual deductible	100%	100%	After annual deductible: 75% (cutting); 70% (non-cutting)	70% after annual deductible	100%
<b>MATERNITY AND FAMILY PLANNING SERVICES</b>							
<i>Office Visits</i>	90%	70% after annual deductible	100% (\$10 copayment for initial visit)	100% (\$10 copayment for initial visit)	75% after annual deductible	70% after annual deductible	100% after confirmation of pregnancy for routine care
<i>Hospital Services (Semi-private room rate)</i>	90%	70% after annual deductible	100%	90%	70% after annual deductible	70% after annual deductible	100%
<b>MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT</b>							
<i>Inpatient<sup>3</sup> (Semi-private room rate)</i>	Regular hospital benefits for hospital facility services; 90% for psychiatrist/psychologist services	Regular hospital benefits for hospital facility services; 70% after annual deductible for psychiatrist/psychologist services	100% for hospital services; 80% for psychiatrist/psychologist services	90% for hospital facility services; 100% for psychiatrist/psychologist services	After deductible: 70% for hospital facility services; \$75 for psychiatrist/psychologist services	After deductible: 70% for hospital facility and psychiatrist/psychologist services	100%
<i>Outpatient<sup>4</sup></i>	90%	70% after annual deductible	100% after \$10 copayment/visit	100% after \$10 copayment/visit	75% after annual deductible	70% after annual deductible	100% after \$12 copayment; 24 visits per year
<b>OTHER SERVICES</b>							
<i>Prescription Drugs – Retail (up to a 30-day supply)</i>	When obtained through a participating pharmacy: Brand Name = 100% after \$20 copayment; Generic = 100% after \$10 copayment. When obtained through a non-participating pharmacy, the above copayments apply, but you must pay the entire cost first and file a claim for reimbursement.						100% after \$10 copayment at Kaiser Permanente pharmacies for brand name and generic on formulary
<i>Prescription Drugs – Mail Order (up to a 90-day supply)</i>	Brand Name = 100% after \$40 copayment; Generic = 100% after \$10 copayment Only available through the HMSA mail order program						100% after \$20 copayment for maintenance drugs on formulary
<i>Outpatient X-ray and Lab Services</i>	80%	70% after annual deductible	100%	100%	70% after annual deductible	70% after annual deductible	100%
<i>Skilled Nursing Facility<sup>5</sup></i>	90% of semi-private room rate	70% after annual deductible	100% of semi-private room rate	90% of semi-private room rate	70% of semi-private room rate after annual deductible	70% of semi-private room rate after annual deductible	100%, up to 60 days per incident
<i>Home Health Care (from a qualified Home Health Agency)</i>	100% up to 150 visits/calendar year	70% after annual deductible up to 150 visits/calendar year	100% up to 365 days per illness or injury	100% up to 365 days/calendar year	75% after annual deductible up to 150 visits/calendar year	70% after annual deductible up to 150 visits/calendar year	100%
<i>Hospice Care</i>	100%	Not covered	100%	100%	75% after annual deductible	70% after annual deductible	100%
<i>Durable Medical Equipment</i>	80% after annual deductible	70% after annual deductible	80%	70%	70% after annual deductible	70% after annual deductible	Not covered

<sup>1</sup>Non-emergency use of an emergency room is not covered.

<sup>2</sup>At a non-Kaiser facility, individual must pay \$25 copayment per visit inside Hawaii service area, or 20% of Reasonable and Customary charges outside Hawaii service area.

<sup>3</sup>Under the HMSA Plans, these services are limited to 30 days/calendar year.

<sup>4</sup>Under the HMSA Plans, these services are limited to 24 visits/calendar year. Of the 24 visits, 12 must be for mental health treatment; the remaining 12 can apply to either substance abuse or mental health treatment. However, treatment for the following conditions will not be subject to these maximums: schizophrenia, schizo-effective disorder, bi-polar mood disorder, delusional disorder, dissociative disorder, major depressive disorder, and bi-polar disorder I and II.

<sup>5</sup>Limited each calendar year to 120 days under the HMSA PPO Plan and HMSA HealthLink Plan; 100 days under HMSA Health Plan Hawaii Plus.