

SCHEDULE D

**Farm Credit Foundations
Hawaii Medical Service Association "HMSA"
PPO Option
(Group No. 72769-1-8 Package: 001)**



Hawaii Medical Service Association (HMSA) PPO

Policy Number: 72769-1-8 Package: 001

Eligibility

Employee: A person employed for at least 20 hours a week for four (4) consecutive weeks, where employee benefits (including wages or salary) and taxes (i.e. FICA, Unemployment Insurance, etc.) are paid for the employee by the employer.

Initial Enrollment Period: The period of time when new employees can enroll for the first of the month following their eligibility date but no later than thirty (30) days following the completion of four (4) consecutive weeks of twenty (20) hours per week.

Eligible dependents include your legally married spouse, domestic partner and child(ren) up to age 19, or up to age 25 if full-time students at an accredited institution (12 or more credit hours). An HMSA Student Certification form must be submitted prior to the beginning of coverage and at any time thereafter upon request by HMSA. Child(ren) must be dependent upon the employee for financial support, unless there is a court order specifying that the employee carry health insurance and the employee can claim the dependent for federal income tax purposes. Child(ren) are defined as: natural child(ren), stepchild(ren), adopted child(ren), and child(ren) that the employee or the employee's spouse have been appointed legal guardianship for by a court of law. Mentally or physically challenged child(ren) over the limiting age are covered as long as they are unmarried, dependent on the employee for support, and they do not have self-sustaining employment. The member must furnish written evidence of such incapacity/dependency and any time thereafter upon request by the Association. The child's coverage shall terminate when the member's coverage terminates or when the child is no longer incapacitated and dependent.

Network Providers

The PPO network consists of a group of doctors, hospitals, labs and other health care providers in an area working together to provide medical care and agree to provide their services at discounted rates. One of the benefits of the PPO program is freedom to use network providers or out-of-network providers. There are two levels of benefits available in this plan. However, the level of benefits you receive will depend on whether or not your doctor is in the network.

2008 Premium Rates

Below is the monthly premium for HMSA coverage:

Full-Time Employee (32+ Hours/week)

	Employee	Employer	Total
Employee Only	35.00	264.72	\$299.72
Employee+ One	125.00	474.44	\$599.44
Family	215.00	684.16	\$899.16

Part-Time Employee (20 – 31 Hours/week)

	Employee	Employer	Total
Employee Only	167.36	132.36	\$299.72
Employee+ One	362.22	237.22	\$599.44
Family	557.08	342.08	\$899.16

Vendor Contact Information

Healthcare	Prescriptions
HMSA 808-948-6111 P.O. Box 860 Honolulu, HI 96808-0860	Pharmacy 800-776-4672 www.hmsa.com

Summary of Benefits and Copayments for 2008

This comparison is intended to provide a condensed explanation of plan benefits. Please refer to the plan brochure and certificate, which may be obtained from your employer, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the certificate, the certificate will take precedence.

Plan Provision	Your Charge	
Benefit	Preferred Providers	Non-Preferred Providers
Annual Deductible	None	\$100 per person \$300 (maximum) per family
Hospital Deductible per Confinement	None	None
Copayment Maximum	\$2,500 per person \$7,500 maximum per family	\$2,500 per person \$7,500 maximum per family
Lifetime Maximum	Unlimited	Unlimited
Student Coverage	Through age 25	Through age 25
Please Note: All benefits for non-preferred providers payable after application of annual deductible, unless otherwise noted.		
	Plan Pays	
Physician Services	Preferred Providers	Non-Preferred Providers
Office Visits	All but \$10 per visit (1)	70%
Hospital Visits	All but \$10 per visit (1)	70%
Hospital Services		
Room & Care – semiprivate room rate; unlimited number of days	90%	70%
Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Laboratory and X-ray	90%	70%
Emergency Room Facility	All but \$50 per visit (1)	All but \$50 per visit (1) *
Ambulatory Surgical Center	90%	70%
(1) This amount does not include tax. * Benefit not subject to annual deductible.		
Inpatient Surgical Services		
Surgery	90%	70%
Anesthesiologist	90%	70%

Benefit	Plan Pays	
	Preferred Providers	Non-Preferred Providers
Outpatient Laboratory & X-Ray Services		
Laboratory and Pathology	100%	70%
X-ray Films and Diagnostic Services	90%	70%
Radiotherapy for Malignancies and Non-Malignancies	90%	70%
Mental Health Services (3)		
Inpatient (4)		
Hospital & Facility Services; 30 days maximum per calendar year	Refer to Hospital Services	Refer to Hospital Services
Psychiatrist & Psychologist Services; 30 visits maximum per calendar year	All but \$10 per visit (2)	70%
Outpatient (4)		
Psychiatrist & Psychologist Services; 24 visits maximum per calendar year	All but \$10 per visit (2)	70%
<p>(2) This amount does not include tax. (3) The member must first receive approval from the Benefit Manager. (4) The following mental illness conditions are not subject to mental health plan maximums: bipolar mood disorder types I and II; delusional disorder, dissociative disorder, major depressive disorder, obsessive-compulsive disorder; schizophrenia and schizo-affective disorder.</p>		
Contraceptive Supplies *		
IUD	50%	50%
Implants	50%	50%
Injectable	50%	50%
Preferred Oral Contraceptives (5)	All but \$5 member copay for covered preferred contraceptives	All but \$8 member copay for covered preferred contraceptives
Diaphragm	All but \$10 member copay per device	All but \$12 member copay per device
Other Methods (i.e. ring and patch) (6)	100% of remaining eligible charge after \$20 member copayment and differential	80% of remaining eligible charge after \$20 member copayment and differential
<p>*Benefits not subject to annual deductible. Copayments will not count towards the annual copayment maximum and benefits paid will not be subject towards the lifetime maximum. (5) Preferred oral contraceptives include: Alesse Contraceptives (Wyeth-Ayerst), Desogen and Mircette (Organon Pharmaceuticals), Nor-Q-D contraceptives (Watson Labs), and Tri-Levlen and Yasmin contraceptives (Berlex Laboratories). (6) Member owes any difference between the average Eligible Charge of the Other Brand Name and the average Eligible Charge for Generic and Preferred products covered by HMSA.</p>		

Benefit	Plan Pays	
	Preferred Providers	Non-Preferred Providers
Other Services		
Ambulance	90%	70%
Air Ambulance	90%	70%
Allergy Testing	90%	70%
Blood & Blood Products	90%	70%
Chemotherapy	90%	70%
Dialysis and Supplies	90%	70%
Hospice Services	100%	Not a Benefit
Medical Equipment, Appliances & Supplies	90%	70%
Newborn Circumcision	90%	70%
Organ Donor Services	90%	70%
Organ & Tissue Transplant (7)	100%	Not a Benefit
Outpatient Injections	90%	70%
Physical/Occupational Therapy	90%	70%
Speech Therapy	90%	70%
Vasectomy	90%	70%
<small>(7) This benefit level is limited to the following transplants: bone marrow, heart, heart and lung, liver, lung and simultaneous kidney/pancreas. You must receive services from a provider that is under contract with us for the specific type of transplant you will receive for those benefits to apply. Refer to your Guide to Benefits for information on other transplants.</small>		

Benefit	Plan Pays	
	Preferred Providers	Non-Preferred Providers
Benefits for Children		
Well Child Care Office Visits	100%	70%*
Well Child Care Immunization	100%	100%*
Well Child Care Lab Tests	100%	70%*
* Benefit not subject to annual deductible		
Benefits for Women		
Pap Smears	100%	70%
Mammography	100%	70%*
Well Woman Exam	100%	70%
Total Maternity Care	Regular Plan Benefits	Regular Plan Benefits
He Hapai Pono (Prenatal care management program)	100%	Not a benefit
Positively Pregnant (Pregnancy workshop)	100%	Not a benefit
* Benefit not subject to annual deductible		
Benefits for Men		
Prostate Specific Antigen	100%	70%
Physical Exams		
Exams	Not a benefit	Not a benefit
Disease Management		
Asthma, Chronic Obstructive Pulmonary Disease or Diabetes	Pharmacist's medication review and education, phone calls from program nurses, information mailed to your home	Not a benefit
Cardiac Disease (CAD and CHF)	Pharmacist's medication review and education, phone calls from program nurses, information mailed to your home. Certain members may qualify for home monitoring equipment.	Not a benefit
Health Assessment	As a Preferred Provider Plan member, you and your covered dependents age 14 and older are entitled to HealthPass, a <u>free</u> annual health assessment from a contracted HealthPass provider that evaluates your health and lifestyle. HealthPass can also include referrals for medical screenings and physical examinations to detect early signs of disease, when appropriate, at no charge to you. The program provides professional counseling to help you design a personal health action program that fosters healthy behavior.	

Benefit	Plan Pays	
	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drugs		
Generic	All but \$5 member copay	80% after \$5 member copay
Preferred Brand Name	All but \$20 member copay	80% after \$20 member copay
Other Brand Name (8)	100% of remaining eligible charge after \$20 member copay and differential	80% of remaining eligible charge after \$20 member copay and differential
Insulin		
Preferred Brand Name	All but \$5 member copay	80% after \$5 member copay
Other Brand Name	All but \$20 member copay	80% after \$20 member copay
Diabetic Supplies		
Preferred Brand Name	100%	100%
Other Brand Name	All but \$20 member copay	All but \$20 member copay
Additional Prescription Benefits		
Other Oral Contraceptives (8)	100% of remaining eligible charge after \$20 member copay and differential	80% of remaining eligible charge after \$20 member copay and differential
Smoking Cessation Devices (limitations apply)	Regular Plan Benefits	Regular Plan Benefits
Spacers for Inhaled Drugs (9)	Special member rates	Special member rates
(8) Member owes the copayment, plus any difference between the average Eligible Charge of the Other Brand Name and the average Eligible Charge for Generic and Preferred drugs covered by HMSA.		
(9) HMSA has arranged with contracted drug manufacturers to offer spacers for inhaled drugs at special member rates.		
Mail Service Prescription Program (From an HMSA contracted provider – 90 day supply)		
Generic	All but \$10 member copay	Not a benefit
Preferred Brand Name	All but \$45 member copay	Not a benefit
Insulin		
Preferred Brand Name	All but \$10 member copay	Not a benefit
Diabetic Supplies		
Preferred Brand Name	100%	Not a benefit
Notes:		
<ul style="list-style-type: none"> When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy. Each drug dispensed is limited to a 30-day supply. A 30-day supply is defined as a supply lasting the member for a period consisting of 30 consecutive days. 		

Benefit	Plan Pays	
	Preferred Providers	Non-Preferred Providers
Vision Care		
Eye examination One per calendar year	100% after \$10 annual deductible	Up to \$40
Lenses (One of the following per calendar year):		
Single	100% after \$10 annual deductible	Up to \$16
Multifocal	100% after \$10 annual deductible	Up to \$25
Contact Lenses	Plan pays up to \$130 after \$25 annual deductible	Up to \$50
Polycarbonate Lenses (for children through age 18)	100%	Up to \$18
Contact Lens Fitting (One contact lens fitting per calendar year)	Up to \$45	Up to \$20
Frames (One frame every other calendar year)	100% after \$15 annual deductible (11)	Up to \$12
(10) Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between HMSA's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of the lenses.		
Chiropractic Benefits		
Office Visits	\$10 per visit (Up to 12 visits per calendar year)	
X-Ray Films	50% of eligible charges up to a maximum of \$50 per calendar year	
Note: To be eligible for payment, chiropractic services must be necessary for the diagnosis or treatment of an injury or illness of the back and performed by a properly licensed or certified chiropractor.		

You are responsible for completion and submission of claims to HMSA if the provider provides them with the claim filing procedures and the claims department address is:

HMSA
Attn: Claims
P.O. Box 860
Honolulu, HI 96808-0860

[This information is deemed to be accurate. In the event that this information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.]