Association of Universities for Research in Astronomy

2017 Medical Benefits at a Glance

	HMSA HPH B	HMSA PPP B	Kaiser HMO	Kaiser Added Choice
In-Network Benefits Only	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Deductible – per plan year				
• One person	N/A	$300	N/A	N/A
• Two or more persons	N/A	$900	N/A	N/A
• Pharmacy expenses apply toward deductible	Excluded	Excluded	Included	Included
Out-of-pocket expense limit - Annually				
• One person	$2,500	$3,000	$2,500	$2,000
• Two or more persons	$7,500	$9,000	$7,500	$6,000
• Pharmacy expenses count toward out-of-pocket limit	$3,600 one person / $4,200 two or more persons (Separate from medical)	$3,600 one person / $4,200 two or more persons (Separate from medical)	NA	NA
Doctor's visits				
• Primary care physician	$20 copay	$17 copay	$20 copay	$20 copay
• Specialist	$20 copay	$17 copay	$20 copay	$20 copay
Hospital services				
• Inpatient	20% coinsurance	20% coinsurance	10% coinsurance	$75 copay per day
• Outpatient	20% coinsurance	20% coinsurance	10% coinsurance	$20 copay per day
Emergency room visits	20% coinsurance	20% coinsurance	$100 copay	$75 copay
Ambulance travel	20% coinsurance	20% coinsurance	20% coinsurance	
Outpatient diagnostic	20% coinsurance	20% coinsurance	20% coinsurance	
• laboratory (blood work only)	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance
• X-Ray	20% coinsurance	20% coinsurance	$10 per day basic lab / 20% coinsurance complex lab	10% coinsurance
• Imaging (MRI, PET , CAT)	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance
Outpatient therapy visits				
• Occupational and speech therapy	$20 copay precertification maybe required	$17 copay precertification maybe required	$20 copay precertification maybe required	$20 copay precertification maybe required
• Physical therapy	$20 copay precertification maybe required	$17 copay precertification maybe required	$20 copay precertification maybe required	$20 copay precertification maybe required
• Chiropractic	$20 copay precertification maybe required	$17 copay precertification maybe required	$20 copay precertification maybe required	$20 copay precertification maybe required
Behavioral health				
• Medical and non-medical professional visits	$20 copay	$17 copay	$20 copay	$20 copay
• Inpatient residential treatment	20% coinsurance	20% coinsurance	20% coinsurance	$75 copay
• Intensive outpatient treatment (IOP)	$20 copay	$17 copay	$20 copay	$20 copay
Prescription drugs				
• Retail Pharmacy	$7 copay (generic) / $30 copay (Preferred Brand & Single Source) / $30+$45 copay (Other Brand) / $100 copay specialty (30 day supply only)	$7 copay (generic) / $30 copay (Preferred Brand & Single Source) / $30+$45 copay (Other Brand) / $100 copay specialty (30 day supply only)	Generic OTC $3 / Other generic $10 / Brand $45 copay / $200 Specialty Rx	Generic OTC $3 / Other generic $10 / Brand $45 copay / $200 Specialty Rx
• Home Delivery Pharmacy	$11 copay (generic) / $65 copay (Preferred Brand) / $65+$135 copay (Other Brand) 90 day supply	$11 copay (generic) / $65 copay (Preferred Brand) / $65+$135 copay (Other Brand) 90 day supply	$6 / $20 / $90 copay / Specialty N/A	$6 / $20 / $90 copay / Specialty N/A
Wellness & Preventive Services	$0	$0	$0	$0
	• Office visits at specified intervals, immunizations, lab and x-rays • Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays • Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam),prostate specific antigen (PSA) test and colorectal cancer screening			
Annual Routine Hearing Exam				
• Routine hearing exam	$20 copay	20% coinsurance	$20 copay	20% coinsurance
• Hearing aids and other hearing-aid related services. (Please see Limitations and Exceptions within the carrier plan summary for defined benefits and details).	80% of applicable charges for standard hearing aids per ear. Non Par Provider 70% of eligible charges subject to Deductible (member responsible for different between total charge and eligible)	50% of applicable charges for standard hearing aids per ear.	60% of applicable charges for standard hearing aids per ear. Medically necessary	60% of applicable charges for standard hearing aids per ear, every 3 years. Medically necessary
• Benefit maximum	1 device per ear every 60 months	1 device per ear every 60 months	1 device per ear every 36 months	1 device per ear every 36 months
Out-of-Network	Not available		Not available	

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2017 Dental Benefits at a Glance

	HMSA L95 (Prepaid Plan)	HMSA PPO D90
Annual Benefit Maximum (per plan year)	None	$2,000
Deductible	None	$25 / $75
Lifetime Orthodontic Benefit Maximum	$1,000	$1,500
Diagnostic & Preventive Services Examples of Diagnostic & Preventative Services include: Cleanings, Exams, X-rays, Fluoride treatment	Plan pays 100%	Plan pays 100% No deductible applies
Basic Services Examples of Basic Services include: X-rays – Periapical, Fillings. Stainless on permanent molars, Space Maintainers, Periodontics, Endodontics	See Schedule for details	Plan pays 70% No deductible applies
Major Services Examples of Major Services include: Crowns, Partial or complete dentures, Bridges, Endosteal Implants	See Schedule for details	12 Month Waiting Period for Bridges, Dentures, Implants & Crowns Plan pays 50% No deductible applies
Orthodontic Services Diagnostic, active & retention treatment for adults and children	Adult & Dependent Child to Age 18 Plan pays up to a maximum of $1,500 paid 25% initially, remaining 75% paid in equal monthly payments over the term of the Treatment Plan, not to exceed thirty-six (36) months	Up to age 18 unless FT student Plan pays up to a maximum of $1,000 paid 25% initially, remaining 75% paid in equal monthly payments over the term of the Treatment Plan, not to exceed thirty-six (36) months

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2017 HMSA Vision Benefits at a Glance

	HMSA HMO Plan	HMSA PPO Plan
Frequency of Benefits (Months)	12 / 12 / 24 (Exams / Lenses or Contacts / Frames)	12 / 12 / 24 (Exams / Lenses or Contacts / Frames)
Routine Eye Exam Copay	$20 copay (covered under medical)	10 copay
Materials Copay (Frames & Lenses)	$15 / $10 copay (lenses / frames)	$15 / $10 copay (lenses / frames)
Frames Eyeglass Lenses - Single, Bifocal & Trifocal	$10 copay	$10 copay
Lens Upgrades Lens Options (Tint, UV, Polycarbonate)	Polycarbonate for children only; Once per calendar year at no cost	Polycarbonate for children only; Once per calendar year at no cost
Contact Lens Exam	$45 Allowance	$45 Allowance
Contact Lenses - Elective	$25 copay; $130 Allowance	$25 copay; $130 Allowance

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2017 Cigna Life / AD&D / STD / LTD Benefits at a Glance

Employer Paid: Life & AD&D	Short Term Disability	Long Term Disability	Hawaii (Temporary Disability) TDI
1x Salary to a max of $250,000	Benefits Begin: 14th day	Benefits Begin: 181st day	Benefits Begin: 8th day
Guarantee Issue: $100,000	Maximum Benefit Period: 26 weeks	Maximum Benefit Period: SSNRA w/RBD	Maximum Benefit Period: 26 weeks
Portability: Included	Percentage of Income Replaced: 60% of Gross Weekly Earnings	Percentage of Income Replaced: 60% of Gross Monthly Earnings	Percentage of Income Replaced: 58% of Weekly Salary
Conversion: Included			
Travel Assistance: Included	Maximum Benefit Amount: $1,385	Maximum Benefit Amount: $6,000	Maximum Benefit Amount: $552 (2015 maximum)
Will Preparation Program: Included	Pre-Existing Conditions: None	Pre-Existing Conditions: 3 months prior / 12 months after	
Will Preparation Program: Included			Note: must have at least 14 weeks of Hawaii employment which the employee was paid for 20 hours or more and earned not less than $400 in 52 weeks preceding the first day of disability.
Note: Employees can buy additional life insurance in $10,000 increments up to 7x Base Annual Earnings or $500,000 ($100,000 coverage guarantee). Voluntary policies can be converted to a private policy if Employees terminates. Employees can also purchases spousal and child life benefits. See HR for eligibility and restrictions.			