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BENEFITS AT-A-GLANCE: **MEDICAL**

All costs are for participating providers only. Please see your* Guide to Benefits *for information on providers outside our network.

	Preferred Provider Plan (423)	Comprehensive Medical (422)
	PPO Network	PPO Network
	Member Cost	Member Cost
Annual Deductible	$0	$0
Annual Copayment Maximum	Single: $2,500 Family: $7,500	Single: $2,500 Family: $7,500
To help maintain your health		
Annual Preventive Health Exam	$0	$0
Annual Well-Woman Exam	$0	$0
Annual Well-Child Care (age 21 & younger)	$0	$0
Preventive Screenings (Grade A & B recommendations of the U.S. Preventive Services Task Force. For a list of all covered screenings, see https://hmsa.com/preventive)	$0	$0
Immunizations (standard & travel)	$0	$0
If you need immediate medical attention		
HMSA Online Care	$0	$0
Urgent Care	$12 copayment	$14 copayment
Emergency Room	20% coinsurance	20% coinsurance
Ambulance (ground or interisland air)	20% coinsurance	20% coinsurance
If you visit a doctor's office or clinic (outpatient)		
Doctor Visit	$12 copayment	$14 copayment
Specialist Visit	$12 copayment	$14 copayment
Physical Therapy	20% coinsurance	20% coinsurance
Radiology - General (e.g., X-ray)	20% coinsurance	20% coinsurance
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	20% coinsurance	20% coinsurance
Lab Tests (e.g., bloodwork)	20% coinsurance	$0
If you have a hospital stay (inpatient)		
Hospital Room & Board	10% coinsurance	20% coinsurance
Surgery	10% coinsurance (cutting) 20% coinsurance (non-cutting)	20% coinsurance (cutting) 20% coinsurance (non-cutting)
Radiology - General (e.g., X-ray)	10% coinsurance	20% coinsurance
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	10% coinsurance	20% coinsurance

	Preferred Provider Plan (423)	Comprehensive Medical (422)
	PPO Network	PPO Network
	Member Cost	Member Cost
Lab Tests (e.g., bloodwork)	10% coinsurance	20% coinsurance
If you're pregnant		
Routine Prenatal & Postnatal Care	10% coinsurance	20% coinsurance
Delivery	10% coinsurance	20% coinsurance
Hospital Room & Board	10% coinsurance	20% coinsurance

Visit hmsa.com to access your suite of well-being tools and to log in to your My Account profile to view in-depth information about your health plan.

Key Terms

Term	Definition
Actual Charge vs. Eligible Charge	Actual Charge: The amount that nonparticipating providers can charge for health care services and products. This amount is usually higher than the eligible charge. Eligible Charge: The maximum amount that participating providers agree to charge for covered health care services and products.
Annual Deductible	The amount you pay each calendar year for covered health care services and products before your plan starts to pay (excluding contraceptives, prescription drugs and supplies, preventive care, and well-child care). Until you meet the deductible each calendar year, you pay 100 percent of your medical expenses.
Coinsurance vs. Copayment	Coinsurance: The percentage of your out-of-pocket costs for covered health care services and products after you've met your deductible (if your plan has one). Copayment: The fixed dollar amount you pay participating providers for covered health care services and products after you've met your deductible (if your plan has one).
Guide to Benefits (GTB)	Your comprehensive guide and legal document that explains your benefits in detail including, exclusions, limitations, terms, and conditions for a specific plan.
HMSA Online Care	A service that immediately lets you connect to a board-certified doctor through video chat to diagnose conditions and prescribe medication 24/7, 365 days a year.
Annual Copayment Maximum	The maximum amount you have to pay for covered services and products (your deductibles, copayments, and coinsurance) in a calendar year before your health plan pays 100 percent of the cost of covered benefits.
Participating Provider vs. Nonparticipating Provider	Participating Provider: Providers who have a contract with HMSA are "in network" and have agreed to charge you a lower rate than nonparticipating providers. Nonparticipating Provider: Providers who don't have a contract with HMSA are considered "out-of-network." They can charge any amount for health care services and products, which can be more than what your plan will pay.
PPO vs. HMO	PPO (Preferred Provider Organization): A plan that gives you the freedom to see any provider, both in and out of network, without a referral. Our network has more than 5,000 doctors, specialists, and other health care professionals. No other health plan in Hawaii has a larger provider network. HMO (Health Maintenance Organization): A plan with a designated primary care provider (PCP) and a health center for all care. If you see providers outside your health center, you'll need a referral from your PCP.
Provider	A physician, hospital, pharmacy, or laboratory.
U.S. Preventive Services Task Force	An independent volunteer panel of national experts in prevention and evidence-based medicine that recommends certain clinical preventive services (e.g., screenings).

Understand important information about your plan: This "benefits at-a-glance"-summary provides a basic overview and comparison of a few of the benefits. Benefits and costs are based on the terms and conditions of your plan, specific exclusions and limitations, coordination of benefits, privacy, third party liability, eligibility requirements, and appeal rights, none of which are described here. For a complete description, see your Guide to Benefits, and any riders, certificates, or amendments. To dispute a decision made by HMSA related to benefits, reimbursement, or any other decision or action by HMSA, please follow the instructions at hmsa.com/appeals.

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BENEFITS AT-A-GLANCE: **DRUG**

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	Drug (408)
	Member Cost
Maximum Out-of-Pocket	Single: $3,600 Family: $4,200
1-30-day supply from pharmacies	
Tier 1: mostly Generic drugs	$7 copayment
Tier 2: mostly Preferred Formulary Drugs	$30 copayment
Tier 3: mostly Non-Preferred Formulary Drugs	$30 copayment plus $45 Tier 3 cost share
Tier 4: mostly Preferred Formulary Specialty Drugs	$100 copayment
Tier 5: mostly Non-Preferred Formulary Specialty Drugs	$200 copayment
84-90-day supply from participating pharmacies or mail-order prescription drug program	
Tier 1: mostly Generic drugs	$11 copayment
Tier 2: mostly Preferred Formulary Drugs	$65 copayment
Tier 3: mostly Non-Preferred Formulary Drugs	$65 copayment plus $135 Tier 3 cost share
Tier 4: mostly Preferred Formulary Specialty Drugs	Not covered
Tier 5: mostly Non-Preferred Formulary Specialty Drugs	Not covered

To learn more about HMSA's drug tiers, please visit hmsa.com/drug-list.

Key Terms

Term	Definition
Cost Share	A portion of the total drug cost you are required to pay in addition to a copayment or coinsurance.
Drug Tiers	The way in which HMSA categorizes drug types that are covered under the plan. The common categories are generic, preferred, brand name, and specialty drugs.
Formulary	A list of drugs that are covered under your drug plan. For a detailed list, please visit hmsa.com/drug-list.
Mail-Order Prescription Drug Program	Program where you can get prescription drugs from our mail-order provider at the best prices possible and have medications delivered to your home. For more information, visit hmsa.com.
Annual Copayment Maximum	The maximum amount you have to pay for covered services (your deductibles, copayments, and coinsurance) in a calendar year before your health plan pays 100 percent of the cost of covered benefits.

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BENEFITS AT-A-GLANCE: **VISION**

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	Vision Standard 1B (0GA)	
	Member Cost	
	Adult	Child
Routine Eye Care		
Eye Exam (one per calendar year)	$10 copayment	$10 copayment
Lenses & Frames* (from participating vision care facilities)		
Eyeglass Lenses	$25 copayment	$25 copayment
Contact Lenses	up to $110 allowance	up to $110 allowance
Polycarbonate Lenses	Not covered	$0 copayment
One Eyeglass Frame (one every other calendar year)	up to $110 allowance	up to $110 allowance
Additional Benefits		
Contact Lens Fitting	Not Covered	Not Covered

*You're eligible for either contact lenses or eyeglass lenses (not both) per calendar year.

Key Terms

Term	Definition
Contact Lens Fitting	An eye exam to ensure that you have the correct fit and prescription for your contacts.
Lenses	Single vision or multifocal lenses for eyeglasses and non-disposable and disposable contact lenses.
Polycarbonate Lens	An impact-resistant eyeglass material that is thinner and lighter than traditional plastic eyeglass lenses. These lenses provide UV protection and are scratch resistant.

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BENEFITS AT-A-GLANCE: **DENTAL**

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	HMSA Group Dental PPO Plan (C53)	HMSA Group Dental HMO Plan (C50)
	PPO Network	Hawaii Family Dental Centers
	Member Cost	Member Cost
Calendar Year Maximum	$1500	$0
Rollover Amount	Up to $500 (max accumulation $1250)	Not applicable
Preventive Care		
Exams (two per calendar year)	$0	$0
Cleaning* (two per calendar year)	$0	$0
Topical Fluoride* (age 18 & younger, two per calendar year)	$0	$0
X-rays (bitewings and full-mouth)	$0	$0
Basic Care		
Fillings (amalgam & composite)	30% coinsurance	$10 per tooth for amalgam; $15 per tooth for anterior composite resin; $75 per tooth for posterior composite resin
Sealants	30% coinsurance	$0
Space Maintainers	30% coinsurance	$25 copayment
Endodontics (root canal therapy)	30% coinsurance	$50 per tooth
Periodontics (gum maintenance)	30% coinsurance	$50 copayment
X-rays (periapical)	30% coinsurance	$0
Major Care		
Waiting Period for New Members	12 Month Waiting Period	12 Month Waiting Period
Crowns, Bridges	50% coinsurance	$200 high noble metal
Dentures	50% coinsurance	$300 complete denture $250 partial denture
Implants	50% coinsurance	Not a covered benefit
Orthodontics	Not a covered benefit	Not a covered benefit

***Enhanced Dental Benefits**: Additional dental services and support is available to enrolled program members for eligible medical conditions. Visit hmsa.com/oralhealth for more information.

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Key Terms

Term	Definition
Calendar Year Maximum	The maximum dollar amount the plan will pay toward covered services during a calendar year.
Rollover Amount	A portion of your unused calendar year maximum that may be carried over to the next calendar year when you have at least one covered dental service per year. You can rollover up to a specific amount per year.
Waiting Period for New Members	The time new members may have to wait until their plan starts paying for certain dental care expenses.

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