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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 (754)	Comprehensive Medical (734)	Health Plan Hawaii Plus (X-S)
	PPO Network	PPO Network	HMO Network
	Member Cost	Member Cost	Member Cost
Annual Deductible	$0	$0	$0
Annual Copayment Maximum	Single: $2,500 Family: $7,500	Single: $2,500 Family: $7,500	Single: $2,500 Family: $7,500
To help maintain your health			
Annual Preventive Health Exam	$0	$0	$0
Annual Well-Woman Exam	$0	$0	$0
Annual Well-Child Care (age 21 & younger)	$0	$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	$0
Immunizations (standard & travel)	$0	$0	$0
If you need immediate medical attention			
HMSA Online Care	$0	$0	$0
Urgent Care	$12 copayment	$14 copayment	$20 copayment
Emergency Room	20% coinsurance	20% coinsurance	$100 copayment
Ambulance (ground or interisland air)	20% coinsurance	20% coinsurance	20% coinsurance
If you visit a doctor's office or clinic (outpatient)			
Doctor Visit	$12 copayment	$14 copayment	$20 copayment
Specialist Visit	$12 copayment	$14 copayment	$20 copayment
Physical Therapy	20% coinsurance	20% coinsurance	$20 copayment
Radiology - General (e.g., X-ray)	20% coinsurance	20% coinsurance	$10 copayment
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	20% coinsurance	20% coinsurance	20% coinsurance
Lab Tests (e.g., bloodwork)	20% coinsurance	$0	$10 copayment
If you have a hospital stay (inpatient)			
Hospital Room & Board	10% coinsurance	20% coinsurance	10% coinsurance
Surgery	10% coinsurance (cutting) 20% coinsurance (non-cutting)	20% coinsurance (cutting) 20% coinsurance (non-cutting)	10% coinsurance (cutting) 10% coinsurance (non-cutting)

	Preferred Provider Plan (754)	Comprehensive Medical (734)	Health Plan Hawaii Plus (X-S)
	PPO Network	PPO Network	HMO Network
	Member Cost	Member Cost	Member Cost
Radiology - General (e.g., X-ray)	10% coinsurance	20% coinsurance	10% coinsurance
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	10% coinsurance	20% coinsurance	10% coinsurance
Lab Tests (e.g., bloodwork)	10% coinsurance	20% coinsurance	10% coinsurance
If you're pregnant			
Routine Prenatal & Postnatal Care	10% coinsurance	20% coinsurance	10% coinsurance
Delivery	10% coinsurance	20% coinsurance	10% coinsurance
Hospital Room & Board	10% coinsurance	20% coinsurance	10% 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).

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

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	Drug (860)	Drug (861)
	Member Cost	**Member Cost**
Maximum Out-of-Pocket	Single: $3,600 Family: $4,200	Single: $3,600 Family: $4,200
1-30-day supply from pharmacies		
Tier 1: mostly Generic drugs	$7 copayment	$7 copayment
Tier 2: mostly Preferred Formulary Drugs	$30 copayment	$30 copayment
Tier 3: mostly Non-Preferred Formulary Drugs	$30 copayment plus $45 Tier 3 cost share	$30 copayment plus $45 Tier 3 cost share
Tier 4: mostly Preferred Formulary Specialty Drugs	$100 copayment	$100 copayment
Tier 5: mostly Non-Preferred Formulary Specialty Drugs	$200 copayment	$200 copayment
84-90-day supply from participating pharmacies or mail-order prescription drug program		
Tier 1: mostly Generic drugs	$11 copayment	$11 copayment
Tier 2: mostly Preferred Formulary Drugs	$65 copayment	$65 copayment
Tier 3: mostly Non-Preferred Formulary Drugs	$65 copayment plus $135 Tier 3 cost share	$65 copayment plus $135 Tier 3 cost share
Tier 4: mostly Preferred Formulary Specialty Drugs	Not covered	Not covered
Tier 5: mostly Non-Preferred Formulary Specialty Drugs	Not covered	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)		Vision Standard 2B (0HA)	
	Member Cost		Member Cost	
	Adult	Child	Adult	Child
Routine Eye Care				
Eye Exam (one per calendar year)	$10 copayment	$10 copayment	Refer to medical section for exam benefits	Refer to medical section for exam benefits
Lenses & Frames* (from participating vision care facilities)				
Eyeglass Lenses	$25 copayment	$25 copayment	$25 copayment	$25 copayment
Contact Lenses	up to $110 allowance	up to $110 allowance	up to $110 allowance	up to $110 allowance
Polycarbonate Lenses	Not covered	$0 copay	Not covered	$0 copay
One Eyeglass Frame (one every other calendar year)	up to $110 allowance	up to $110 allowance	up to $110 allowance	up to $110 allowance
Additional Benefits				
Contact Lens Fitting	Not Covered	Not Covered	Not Covered	Not Covered

*You're eligible for either contact lenses or frames per calendar year. You're responsible for any charges above the allowed amount for contact lenses and frames.

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: **COMPLEMENTARY CARE**

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	Acupuncture & Massage Therapy (N04)*
	Member Cost
Office Visits	$10 copayment

*A maximum number of visits per calendar year may apply.

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.