hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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 (762)	Comprehensive Medical (730)	Health Plan Hawaii Plus (E-V)
	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 (762)	Comprehensive Medical (730)	Health Plan Hawaii Plus (E-V)
	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).

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

	Drug (972)	Drug (973)
	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.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

	Vision (DU) – For PPO Network Plans		Vision (DV) – For HMO Network Plans	
	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	$10 copayment	$10 copayment	$10 copayment	$10 copayment
Contact Lenses	$25 copayment (up to $130 allowance)	50% of charge	$25 copayment (up to $130 allowance)	50% of charge
Polycarbonate Lenses	Not covered	$0	Not covered	$0
One Eyeglass Frame (from select group, once per 24 months)	$15 copayment	$15 copayment	$15 copayment	$15 copayment
Additional Benefits				
Contact Lens Fitting (one per calendar year)	All charges less $45 plan payment	50% of eligible charge	All charges less $45 plan payment	50% of eligible charge

*You're eligible for either contact lenses or eyeglass frames (not both) in the same 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.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

	HMSA Group Dental PPO Plan(C53)
	PPO Network
Calendar Year Maximum	$1500
Rollover Amount	Up to $500 (max accumulation $1250)
Preventive Care	**Member Cost**
Exams (two per calendar year)	$0
Cleaning* (two per calendar year)	$0
Topical Fluoride* (age 18 & younger, two per calendar year)	$0
X-rays (bitewings & full-mouth)	$0
Basic Care	
Fillings (amalgam & composite)	30% coinsurance
Sealants	30% coinsurance
Space Maintainers	30% coinsurance
Endodontics (root canal therapy)	30% coinsurance
Periodontics (gum maintenance)	30% coinsurance
X-rays (periapical)	30% coinsurance
Major Care	
Waiting Period for New Members	12 Month Waiting Period
Crowns, Bridges, Dentures, Implants	50% coinsurance
Orthodontics	Not a 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.

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 with a maximum amount.
Waiting Period for New Members	The time new members may have to wait until their plan starts paying for certain dental care expenses.

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.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFITS AT-A-GLANCE: **ADDITIONAL BENEFITS**

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

LIFE/AD&D

	Benefit Amounts
Life Insurance	$30,000 benefit per eligible subscriber
Accidental Death & Dismemberment	$30,000 benefit per eligible subscriber
Accelerated Death Benefit	$15,000 benefit per eligible subscriber

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.

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻŌlelo Hawaiʻi, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711. まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ຟຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei 'au'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

NMM_1000_24715_1557_R