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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 (683) PPO Network	Health Plan Hawaii Plus (Y-Q) HMO Network
	Member Cost	**Member Cost**
Annual Deductible	$0	$0
Annual Copayment Maximum	Single: $2,500 Family: $7,500	Single: $1,500 Family: $4,500
To help maintain your health		
Annual Well-Woman Exam	$0	$0
Annual Well-Child Care (age 6 & younger)	$0	$0
Colonoscopy Screening	$0	$0
Mammography Screening	$0	$0
Immunizations (standard)	$0	$0
If you need immediate medical attention		
HMSA Online Care	$0	$0
Urgent Care	$0	$0
Emergency Room	$0	$0
Ambulance (ground or interisland air)	$0	$0
If you visit a doctor's office or clinic (outpatient)		
Doctor Visit	$0	$0
Specialist Visit	$0	$0
Physical Therapy	$0	$0
Radiology - General (e.g., X-ray)	$0	$0
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	$0	$0
Lab Tests (e.g., bloodwork)	$0	$0
If you have a hospital stay (inpatient)		
Hospital Room & Board	$0	$0
Surgery	$0 (cutting) $0 (non-cutting)	$0 (cutting) $0 (non-cutting)
Radiology - General (e.g., X-ray)	$0	$0
Radiology - Other (e.g., MRI, CT scan, Ultrasound)	$0	$0
Lab Tests (e.g., bloodwork)	$0	$0

	Preferred Provider Plan (683)	Health Plan Hawaii Plus (Y-Q)
	PPO Network	HMO Network
	Member Cost	Member Cost
If you're pregnant		
Routine Prenatal & Postnatal Care	$0	$0
Delivery	$0	$0
Hospital Room & Board	$0	$0

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 (812)
	Member Cost
Maximum Out-of-Pocket	N/A
1-30-day supply from pharmacies	
Generic	$0
Preferred	$2 copayment
Non-Preferred	$2 copayment
Specialty	$2 copayment
84-90-day supply from participating pharmacies or mail-order prescription drug program	
Generic	$0
Preferred	$0
Non-Preferred	$0
Specialty	$0

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 (EM)	
	Member Cost	
	Adult	Child
Routine Eye Care		
Eye Exam (one per calendar year)	$0	$0
Lenses & Frames - by prescription to correct visual acuity		
Eyeglass Lenses	$0 (Plan pays up to $400)	$0
Contact Lenses	$0 (Plan pays up to $p00)	$0
Polycarbonate Lenses	$0 (See "Eyeglass Lenses" benefit above)	$0
Eyeglass Frame	$0 (Plan pays up to $400) 2ŦŜfλƎʎōfŜ ŎKIꞏNƎŜ	$0
Additional Benefits		
Contact Lens Fitting (one per calendar year)	$0	$0
Lasik Surgery	Plan pays up to $5000 , per calendar year	Not a benefit
Lens Enhancements (Tinting, UV Lenses, Anti-Reflective Coating)	$0 (See “Eyeglass Lenses” benefit above)	$0
Prescription Sunglasses ó/2dzyúă ű2ǿIꞏNŘă ! LJLJfλIꞏyŎŜ aIꞏÈʎYdzYú	/2ØŜNŜŘ ǿλűK LJN2LJŜN LJNŜăÕNλLJűλ2y, (payment is included in the payment for lenses and frames and subject to the benefit limitations)	$0, /2ØŜNŜŘ ǿλűK LJN2LJŜN LJNŜăÕNλLJűλ2y
! LJLJfλIꞏyŎŜ aIꞏÈʎYdzY LJŜN /IꞏfŜyŘIꞏN ¸ŜIꞏN	2 Pairs of Glasses or 1 Pair of Glasses + 1 Set of Contacts or 2 sets of Contacts	2 Pairs of Glasses or 1 Pair of Glasses + 1 Set of Contacts or 2 sets of Contacts

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.

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: **ADDITIONAL BENEFITS**

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CHIROPRACTIC, ACCUPUNTURE & MASSAGE

	Chiropractic Care, Acupuncture & Massage Therapy (A31)*
	Preferred Provider Plan
	Member Cost
Office Visits	$0 copayment

* All services must be medically necessary. Services after the initial patient exam may be subject to verification of medical necessity. Exclusions and limitations apply. Please consult your *Guide to Benefits* for a complete description.

ACTIVE & FIT

	Active & Fit Program
	Member Cost
Fitness Facility Access	$100 Annual Member Fee
Home Exercise Program	$10 Annual Member Fee