



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

|                                   | Preferred Provider Plan (762) |
|-----------------------------------|-------------------------------|
|                                   | PPO Network                   |
|                                   | Member Cost                   |
| Lab Tests (e.g., bloodwork)       | 10% coinsurance               |
| <b>If you're pregnant</b>         |                               |
| Routine Prenatal & Postnatal Care | 10% coinsurance               |
| Delivery                          | 10% coinsurance               |
| Hospital Room & Board             | 10% coinsurance               |

Visit [hmsa.com](https://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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Actual Charge vs. Eligible Charge</b>                    | Actual Charge: The amount that nonparticipating providers can charge for health care services and products. This amount is usually higher than the eligible charge.<br>Eligible Charge: The maximum amount that participating providers agree to charge for covered health care services and products.                                                                                                                                                                                                                         |
| <b>Annual Deductible</b>                                    | 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.                                                                                                                                                                                                          |
| <b>Coinsurance vs. Copayment</b>                            | 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).<br>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).                                                                                                                                                                                    |
| <b>Guide to Benefits (GTB)</b>                              | Your comprehensive guide and legal document that explains your benefits in detail including, exclusions, limitations, terms, and conditions for a specific plan.                                                                                                                                                                                                                                                                                                                                                               |
| <b>HMSA Online Care</b>                                     | 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.                                                                                                                                                                                                                                                                                                                                                              |
| <b>Annual Copayment Maximum</b>                             | 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.                                                                                                                                                                                                                                                                                                              |
| <b>Participating Provider vs. Nonparticipating Provider</b> | Participating Provider: Providers who have a contract with HMSA are "in network" and have agreed to charge you a lower rate than nonparticipating providers.<br>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.                                                                                                                                    |
| <b>PPO vs. HMO</b>                                          | 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.<br>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. |
| <b>Provider</b>                                             | A physician, hospital, pharmacy, or laboratory.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>U.S. Preventive Services Task Force</b>                  | 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](https://hmsa.com/appeals).



## BENEFITS AT-A-GLANCE: DRUG

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|                                                                                               | Drug (972)                                     |
|-----------------------------------------------------------------------------------------------|------------------------------------------------|
|                                                                                               | <b>Member Cost</b>                             |
| Maximum Out-of-Pocket                                                                         | Single: \$3,600<br>Family: \$4,200             |
| <b>1-30-day supply from pharmacies</b>                                                        |                                                |
| Tier 1: mostly Generic drugs                                                                  | \$7 copayment                                  |
| Tier 2: mostly Preferred Formulary Drugs                                                      | \$30 copayment                                 |
| Tier 3: mostly Non-Preferred Formulary Drugs                                                  | \$30 copayment<br>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                                |
| <b>84-90-day supply from participating pharmacies or mail-order prescription drug program</b> |                                                |
| Tier 1: mostly Generic drugs                                                                  | \$11 copayment                                 |
| Tier 2: mostly Preferred Formulary Drugs                                                      | \$65 copayment                                 |
| Tier 3: mostly Non-Preferred Formulary Drugs                                                  | \$65 copayment<br>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](https://hmsa.com/drug-list).

## Key Terms

| Term                                        | Definition                                                                                                                                                                                                               |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cost Share</b>                           | A portion of the total drug cost you are required to pay in addition to a copayment or coinsurance.                                                                                                                      |
| <b>Drug Tiers</b>                           | 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.                                                             |
| <b>Formulary</b>                            | A list of drugs that are covered under your drug plan. For a detailed list, please visit <a href="https://hmsa.com/drug-list">hmsa.com/drug-list</a> .                                                                   |
| <b>Mail-Order Prescription Drug Program</b> | 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 <a href="https://hmsa.com">hmsa.com</a> . |
| <b>Annual Copayment Maximum</b>             | 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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