hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

Prepared exclusively for:

GCA MEWA

This comparison is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply.
Please refer to the plan Guide to Benefits or certificate, which may be obtained from your employer, for complete information on benefits and provisions.
In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits or certificate, the Guide to Benefits or certificate will take precedence.

PLAN PROVISIONS	PPO – (862)		HMO – (Y-B)
	Participating Providers	Nonparticipating Providers	In-Network
Overall Deductible (annual)	For participating providers $0 For non-participating providers $100 per person Maximum: $300 per family Doesn't apply to contraceptives, emergency services, prescription drugs and supplies, preventive care and well-child care.		$0
Out-of-pocket Limit (annual)	$2,500 per person/$7,500 per family (medical plan coverage) $3,600 per person/$4,200 per family (prescription drug coverage)		$2,500 per person/$7,500 per family (medical plan coverage) $3,600 per person/$4,200 per family (prescription drug coverage)
	YOUR COST		**YOUR COST**
If you visit a health care provider's office or clinic			
Primary Care or Specialist Visit	$12 copay/visit	30% co-insurance	$20 copay/visit
Preventive care (Well Child Care Physician Visit through age 21)	No charge	30% co-insurance	No charge
Screening (Grade A & B recommendations of the U.S. Preventive Services Task Force)	No charge	30% co-insurance	No charge
Immunization (standard and travel)	No charge	30% co-insurance	No charge
If you have a test			
Diagnostic Test	10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) 20% co-insurance (outpatient)
X-ray	10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) $10 copay (outpatient)
Blood Work	10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) $10 copay (outpatient)
Imaging (CT/PET scans, MRI's)	10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) 20% co-insurance (outpatient)
If you have outpatient surgery			
Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	10% co-insurance
Physician Visit	$12 copay/visit	30% co-insurance	$20 copay/visit
Surgeon Fees	10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)	$20 copay (cutting) $20 copay (non-cutting)

MEDICAL SERVICES	PPO – (862)		HMO – (Y-B)
	YOUR COST		YOUR COST
	Participating Providers	Nonparticipating Providers	In-Network
If you need immediate medical attention			
Emergency Room Services – Physician Visit	$12 copay/visit	$12 copay/visit	No charge
Emergency Room Services – Emergency Room	20% co-insurance	20% co-insurance	$100 copay/visit
Emergency Medical Transportation (air)	20% co-insurance	30% co-insurance	20% co-insurance
Emergency Medical Transportation (ground)	20% co-insurance	30% co-insurance	20% co-insurance
Urgent Care	$12 copay/visit	30% co-insurance	$20 copay/visit
If you have a hospital stay			
Facility Fee (e.g., hospital room)	10% co-insurance	30% co-insurance	10% co-insurance
Physician Visit	$12 copay/visit	30% co-insurance	10% co-insurance
Surgeon Fee	10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)	10% co-insurance (cutting) 10% co-insurance (non-cutting)
If you have mental health, behavioral health, or substance abuse needs			
Mental / Behavioral Health Physician services	10% co-insurance (inpatient) $12 copay/visit (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) $20 copay/visit (outpatient)
Mental / Behavioral Health Hospital and facility services	10% co-insurance (inpatient) 10% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) No charge (outpatient)
Substance Use Disorder Physician services	10% co-insurance (inpatient) $12 copay/visit (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) $20 copay/visit (outpatient)
Substance Use Disorder Hospital and facility services	10% co-insurance (inpatient) 10% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)	10% co-insurance (inpatient) No charge (outpatient)
If you are pregnant			
Prenatal and Postnatal Care	10% co-insurance	30% co-insurance	10% co-insurance
Delivery (surgery)	10% co-insurance	30% co-insurance	10% co-insurance
Inpatient services (hospital room and board)	10% co-insurance	30% co-insurance	10% co-insurance
If you need help recovering or have other special health needs			
Home Health Care	No charge	30% co-insurance	No charge
Rehabilitation Services	20% co-insurance	30% co-insurance	$20 copay/visit
Skilled Nursing Care	10% co-insurance	30% co-insurance	10% co-insurance
Durable Medical Equipment	20% co-insurance	30% co-insurance	20% co-insurance
Hospice Service	No charge	Not covered	No charge

ONLINE CARE	As an HMSA member, you and your covered dependents may access HMSA's Online Care through www.hmsa.com.
WELL-BEING CONNECT	As an HMSA member, you and your covered dependents age 18 and older are entitled to Well-Being Connect, an online health portal that includes a well-being assessment that evaluates your health and lifestyle at no cost. The assessment helps you design a personal well-being plan that fosters healthy behavior.

PRESCRIPTION DRUGS	**DRUG 777**		**DRUG 778**	
	YOUR COST		**YOUR COST**	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
TIER 1: MOSTLY GENERIC DRUGS	$7 copay/prescription	$7 copay and 20% co-insurance/prescription	$7 copay/prescription	$7 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
TIER 2: MOSTLY PREFERRED DRUGS	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	$30 copay/prescription	$30 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
TIER 3: MOSTLY OTHER BRAND NAME DRUGS	$30 copay/prescription plus $45 Tier 3 Cost Share	$30 copay and 20% co-insurance/prescription plus $45 Tier 3 Cost Share	$30 copay/prescription plus $45 Tier 3 Cost Share	$30 copay and 20% co-insurance/prescription plus $45 Tier 3 Cost Share
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
TIER 4: MOSTLY PREFERRED SPECIALTY DRUGS	$100 copay/prescription	Not covered	$100 copay/prescription	Not covered
	Retail benefit limited to a 30-day supply.		Retail benefit limited to a 30-day supply.	
TIER 5: MOSTLY OTHER BRAND NAME SPECIALTY DRUGS	$200 copay/prescription	Not covered	$200 copay/prescription	Not covered
	Retail benefit limited to a 30-day supply.		Retail benefit limited to a 30-day supply.	
MAIL SERVICE PRESCRIPTION PROGRAM (From an HMSA contracted provider)				
TIER 1: MOSTLY GENERIC DRUGS	$11 copay/prescription	Not covered	$11 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
TIER 2: MOSTLY PREFERRED DRUGS	$65 copay/prescription	Not covered	$65 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
TIER 3: MOSTLY OTHER BRAND NAME DRUGS	$65 copay/prescription plus $135[1] Tier 3 Cost Share	Not covered	$65 copay/prescription plus $135[1] Tier 3 Cost Share	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
TIER 4: MOSTLY PREFERRED SPECIALTY DRUGS	Not covered	Not covered	Not covered	Not covered
TIER 5: MOSTLY OTHER BRAND NAME SPECIALTY DRUGS	Not covered	Not covered	Not covered	Not covered

- **NOTE:** When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy.

[1] $45 retail Tier 3 cost share times 3 month supply

VISION CARE SERVICES for Adults	VISION DU		VISION DV	
	YOUR COST		YOUR COST	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
EYE EXAMINATION One per calendar year	$10 copay	All charges less $40 plan payment	Refer to Medical section for exam benefits	Not covered
LENSES (One of the following) One pair per calendar year:				
Single	$10 copay	All charges less $16 plan payment	$10 copay	All charges less $16 plan payment
Multifocal	$10 copay	All charges less $25 plan payment	$10 copay	All charges less $25 plan payment
Contact Lenses	$25 copay plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment	$25 copay plus remaining eligible charge after $130 plan payment	All charges less $50 plan payment
ADDITIONAL BENEFITS				
Contact Lens Fitting; One fitting per calendar year	All charges less $45 plan payment	All charges less $20 plan payment	All charges less $45 plan payment	All charges less $20 plan payment
FRAMES (Standard/Selected Frames) One frame every 24 months	$15 copay	All charges less $12 plan payment	$15 copay	All charges less $12 plan payment
VISION CARE SERVICES for Children (through age 18)				
EYE EXAMINATION One per calendar year	$10 copay	50% of eligible charge	Refer to Medical section for exam benefits	Not covered
LENSES (One of the following) One pair per calendar year:				
Single	$10 copay	50% of eligible charge	$10 copay	50% of eligible charge
Multifocal	$10 copay	50% of eligible charge	$10 copay	50% of eligible charge
Contact Lenses	50% of charge	50% of charge	50% of charge	50% of charge
ADDITIONAL BENEFITS				
Polycarbonate Lenses; One pair per calendar year	None	50% of eligible charge	None	50% of eligible charge
Contact Lens Fitting; One fitting per calendar year	50% of eligible charge	50% of eligible charge	50% of eligible charge	50% of eligible charge
FRAMES (Standard/Selected Frames) One frame every 24 months	$15 copay	50% of eligible charge	$15 copay	50% of eligible charge

- Frames must be chosen from a group selected by the provider. If the member chooses a frame outside of the group, the member will have to pay any difference between HMSA's allowance and the provider's charge for the frames. If the member replaces only the lenses of his/her glasses, the allowance for frames cannot be applied to the cost of lenses and contact lenses.
- If the member receives benefits for contact lenses, the member is not eligible for frames in the same year. If benefits for frames have been paid in a calendar year, those benefits will be deducted from the benefits for any contact lenses furnished in the same calendar year.
- Exclusions: Sunglasses, prescription inserts for diving masks and any protective eyewear, nonprescription industrial safety goggles, nonstandard items for lenses, including tinting, blending, oversized lenses, invisible bifocals or trifocals, and repair and replacement of frame parts and accessories.
- Contact lenses following cataract surgery are not a benefit.

DENTAL CARE SERVICES	PARTICIPATING PROVIDER PROGRAM (V48)
PROVISIONS	**Refer to Dental Guide to Benefits for benefit and age limitations.**
Calendar Year Maximum	$1,000
Calendar Year Rollover	Accumulate up to $1,000[2]
Choice of Dentists	HMSA Participating Provider Network (Par) or any licensed Dentist (Non-Par)
PREVENTIVE CARE	**YOUR COPAYMENT**
Exams	None Two per calendar year
Cleaning	None Two per calendar year
Topical Fluoride	None Two per calendar year; age 18 and under
X-rays	None One set of bitewings per calendar year and one full mouth x-ray every 3 years
ROUTINE CARE	
X-Rays - Periapical	30% Up to six per date of service
Fillings	30%
Sealants on permanent molars	30% One per lifetime; age 16 and under
Space Maintainers	30% Age 13 and under
Endodontics	30%
Periodontics	30%
MAJOR CARE	
Waiting Period – New Members	12 Months for Bridges, Dentures, Implants & Crowns
Crowns, Bridges	30%
Dentures	
Partial upper or lower denture	30%
Complete upper or lower denture	30%
Endosteal Implants	30%
ENHANCED DENTAL BENEFITS	Members diagnosed with diabetes, coronary artery disease, oral cancer and women who are pregnant may be eligible for additional services under the Enhanced Dental Benefit program. For more information visit hmsa.com/oralhealth.

[2] Rollover Amount is up to $350 per year if at least one dental service is received and benefits paid in the prior calendar year do not exceed $500.

Important Information

All copayments shown are based on eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. All services received from a nonparticipating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge. **Please note**: Eligible charge does not include excise tax or other tax. You are responsible for all taxes related to the medical care you receive.

For Health Plan Hawaii and Health Plan Hawaii Plus, HMSA requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as their PCP.

Women do not need prior authorization from HMSA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in their health center who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Services from a non-network provider are not covered with the exception of emergency care and/or referrals from your in-network PCP.

For information on how to select a PCP or a list of participating health care providers, visit hmsa.com/search/providers. If you require a hard copy listing, please visit an HMSA office nearest you or call HMSA Customer Service at 948-6372 on Oahu or toll-free at 1-800-776-4672.