Preferred Provider Plan – B

BENEFIT PLAN SUMMARY

This summary 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 summary and the language contained within the Guide to Benefits or certificate, the latter will take precedence.

HMSA
Blue Cross
Blue Shield
of Hawai'i

An Independent Licensee of the Blue Cross and Blue Shield Association

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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.

Note: Asterisk * = Indicates annual deductible applies.

PLAN PROVISIONS	PREFERRED PROVIDER PLAN – B (808)	
	Participating Providers	Nonparticipating Providers
Lifetime Maximum	Unlimited	
Annual Copayment Maximum	$3,000 per person Maximum: $9,000 per family	
Annual Deductible	$300 per person Maximum: $900 per family	
	YOUR COPAYMENT	
PHYSICIAN SERVICES		
Office Visits	$17*	30%*
Hospital Visits	$17*	30%*
Emergency Room	$17*	$17*
HOSPITAL AND FACILITY SERVICES		
Hospital Room and Board; Semiprivate Room Rate; unlimited number of days	20%*	30%*
Emergency Room	$100*	$100*
SURGICAL SERVICES		
Surgical Procedures	20%*	30%*
LABORATORY AND RADIOLOGY		
Diagnostic Testing	20%*	30%*
Laboratory and Pathology	None* (outpatient) 20%* (inpatient)	30%*
X-Ray and Other Radiology	20%*	30%*
OTHER MEDICAL SERVICES		
Ambulance (ground)	20%*	30%*
Durable Medical Equipment and Supplies	20%*	30%*
BENEFITS FOR CHILDREN		
Well Child Care Immunizations (through age 21)	None	None
Well Child Care Physician Office Visits (through age 21)	None	30%
BENEFITS FOR MEN		
Prostate Specific Antigen (PSA) Test (screening)	None	30%*
BENEFITS FOR WOMEN		
Mammography (screening)	None	30%
Pap Smears (screening)	None	30%*
Well Woman Exam	None	30%*
ONLINE CARE	As an HMSA member, you and your covered dependents may access HMSA's Online Care through www.hmsa.com. Your copayment is $10 for up to 10 minutes; $5 for an additional 5 minute extension. Each session is limited to a total of 15 minutes.	
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.	

SPECIAL BENEFITS	PREFERRED PROVIDER PLAN – B (808)	
	YOUR COPAYMENT	
LIMITED Rx BENEFITS[1]	Participating Providers	Nonparticipating Providers
Oral Chemotherapy Drugs	None	None
Diabetic Drugs		
Generic	20%	20%
Preferred Brand Name	20%	20%
Other Brand Name	30%	30%
Diabetic Supplies		
Preferred Brand Name	None	None
Other Brand Name	20%	20%
Insulin		
Preferred Brand Name	20%	20%
Other Brand Name	30%	30%
Oral Contraceptives & Other Contraceptive Methods (i.e. ring and patch)		
Generic	None	20%
Preferred Brand Name	20%	20%
Other Brand Name	30%	30%
Diaphragms (per device)	None	$10
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs[2]	None	20%
NOTE:		
• Each drug dispensed is limited to a 30-day supply. A 30-day supply is defined as a supply lasting the member for a period consisting of 30 consecutive days.		
MAIL SERVICE PRESCRIPTION PROGRAM[3] (From an HMSA contracted provider – 90 day supply)		
Oral Chemotherapy Drugs	None	Not covered
Diabetic Drugs		
Generic	20%	Not covered
Preferred Brand Name	20%	Not covered
Other Brand Name	30%	Not covered
Diabetic Supplies		
Preferred Brand Name	None	Not covered
Other Brand Name	20%	Not covered
Insulin		
Preferred Brand Name	20%	Not covered
Other Brand Name	30%	Not covered
Oral Contraceptives & Other Contraceptive Methods (i.e. ring and patch)		
Generic	None	Not covered
Preferred Brand Name	20%	Not covered
Other Brand Name	30%	Not covered
Diaphragms (per device)	None	Not covered
U.S. Preventive Services Task Force (USPSTF) Recommended Drugs[2]	None	Not covered
NOTE:		
• If you have an HMSA drug rider with similar benefits, your drug rider benefits apply. There shall be no duplication or coordination of benefits between this plan and your HMSA drug plan.		
[1] Copayments will not count towards the annual copayment maximum.		
[2] USPSTF A & B Recommendations		
[3] To utilize the mail order program, only credit card payments are accepted.		