

RCUH Medical Insurance Summary: Plan Comparison: In-Network Coverages

July 1, 2026 - June 30, 2027

HMSA Comprehensive Medical Basic	HMSA Comprehensive Medical	HMSA Preferred Provider	HMSA HMO	Kaiser HMO Standard (Plan A)	Kaiser HMO Comprehensive (Plan B)
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Links to Full Plan Document and Summary of Benefits & Coverages (SBC)

Plan Document SBC	Plan Document SBC	Plan Document SBC	Plan Document SBC	Benefit & Payment SBC	Benefit & Payment SBC
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Plan Type	PPO: Preferred Provider Organization			HMO: Health Maintenance Organization		
In-Network	Blue Cross Blue Shield Find a Provider			Hawai'i Locations only HMSA Facility and Primary Care Physician (PCP)	Hawai'i Locations only Kaiser Permanente Hawaii Find a Doctor & Location	
Mainland Coverage	Blue Cross Blue Shield			Out of network	Out of network <i>*Additional coverage available for dependents outside service area</i>	
Annual Deductible (calendar year)	Individual: \$500 Family: \$1,500	\$0	\$0	\$0	\$0	\$0
Annual Out of Pocket Maximum: Medical (calendar year)	Individual: \$4,600 Family: \$12,000	Individual: \$2,500 Family: \$7,500	Individual: \$2,500 Family: \$7,500	Individual: \$2,500 Family: \$7,500	Individual: \$3,000 Family: \$9,000	Individual: \$2,500 Family: \$7,500
Annual Out of Pocket Maximum: Drug	Individual: \$3,600 Family: \$4,200			Applies toward the maximum out of pocket limit		
Monthly Premium Cost (Active Employee cost only)	Single: \$270.50 2-Party: \$540.97 Family: \$947.09	Single: \$309.64 2-Party: \$619.24 Family: \$1,084.06	Single: \$390.31 2-Party: \$780.63 Family: \$1,366.50	Single: \$357.89 2-Party: \$715.79 Family: \$1,252.98	Single: \$203.71 2-Party: \$407.42 Family: \$712.99	Single: \$236.24 2-Party: \$472.47 Family: \$826.83
To help maintain your health						
Annual Preventive Health Exam	no charge					
If you need immediate medical attention						
Urgent Care	25% coinsurance	\$14 per visit	\$12 per visit	\$20 copayment	\$25 per visit	\$15 per visit
Emergency Room	25% coinsurance	20% coinsurance	20% coinsurance	\$100 copayment	20% coinsurance	\$100 copay
Ambulance (ground or interisland air)	25% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
If you visit a doctor or clinic (outpatient)						
Doctor or Specialist Visit (includes mental health)	25% coinsurance	\$14 per visit	\$12 per visit	\$20 per visit	\$25 per visit	\$15 per visit no charge for children under 17
Diagnostic Tests (X-ray, blood work)	25% coinsurance	\$0	20% coinsurance	\$10 per visit	20% coinsurance	\$15 per dept/day
Imaging (CT/PET scans, MRI's)	25% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Surgery (outpatient)	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	\$25 per visit	10% coinsurance
If you have a hospital stay (inpatient)						
Hospitalization/Inpatient services	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	\$150 per day	10% coinsurance
If you are pregnant						
Routine Prenatal, Postnatal Visits	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	\$0	\$0
Delivery, Hospital Room & Board	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	\$150 copay per day	\$0
Other coverages						
Outpatient prescription drugs	Refer to Drug Riders: PPO Plan Types & HMO Plan Tier 1: \$7 copayment; Tier 2: \$30 copayment; Tier 3: \$30 copayment & \$45 cost share; Tier 4: 20% coinsurance; Tier 5: 25% coinsurance				Refer to Plan Documents \$3 generic maintenance; \$10 other generic; \$45 brand name; \$200 specialty	
Gym Membership Discount	HMSA Active & Fit Program				Kaiser Fit Rewards	
Vision Exam	\$10 per visit				no charge	
Glasses or Contacts	\$110 allowance for frames or contacts		\$130 allowance for frames or contacts		\$150 allowance for glasses or contacts	
Chiropractic Office Visits	n/a	\$14 per visit	\$12 per visit	\$10 per visit	20 visits @ \$20/visit Refer to Kaiser CAMN+ flyer	
Alternative Medicine (Acupuncture, Massage Therapy, Naturopathy)	Refer to HMSA Complementary Care Rider					

This summary is a brief overview of select benefits for vendor and plan comparison purposes only. Refer to Full Plan Documents and Summary of Benefits & Coverages (SBC) for details of plan coverage and applicable exclusions.