RCUH Health Insurance Plan Comparison for July 1, 2023 - June 30, 2024: In-Network Coverages

	HMSA Comprehensive Medical Basic	**HMSA Comprehensive Medical**	**HMSA PPO**	**HMSA HMO** *(formerly Health Plan Hawaii Plus)*	**Kaiser HMO Standard - Plan A** *(formerly Plan A)*	**Kaiser HMO Comprehensive - Plan B** *(formerly Plan B)*
Plan Type	PPO	PPO	PPO	HMO	HMO	HMO
In-Network	Blue Cross Blue Shield https://www.hmsa.com/search/providers/	Blue Cross Blue Shield https://www.hmsa.com/search/providers/	Blue Cross Blue Shield https://www.hmsa.com/search/providers/	HMSA Facility and Primary Care Physician (PCP) https://hmsa.com/search/providers/	Kaiser Permanente Hawaii https://healthy.kaiserpermanente.org/hawaii/doctors-locations#/search-form	Kaiser Permanente Hawaii https://healthy.kaiserpermanente.org/hawaii/doctors-locations#/search-form
Mainland Coverage	Mainland care: Blue Cross Blue Shield	Mainland care: Blue Cross Blue Shield	Mainland care: Blue Cross Blue Shield	Out of network: Enrollment limited to Hawaii Residents only	Out of network: Enrollment limited to Hawaii Residents only	Out of network: Enrollment limited to Hawaii Residents only
Annual Deductible	Individual: $500 Family: $1,500	$0	$0	$0	$0	$0
Annual Out of Pocket Maximum	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
Monthly Premium Cost (Employee cost only)	Single: $234.30 2-Party: $468.60 Family (3+): $820.33	Single: $268.88 2-Party: $537.73 Family (3+): $941.30	Single: $340.18 2-Party: $680.34 Family (3+): $1,190.91	Single: $311.45 2-Party: $622.90 Family (3+): $1,090.32	Single: $199.33 2-Party: $398.67 Family (3+): $697.67	Single: $231.16 2-Party: $462.32 Family (3+): $809.05
To help maintain your health						
Annual Preventive Health Exam	no charge	no charge	no charge	no charge	no charge	no charge
Annual Well-Child care (age 21 & younger)	no charge	no charge	no charge	no charge	no charge	no charge
Preventive Screenings, Immunization	no charge	no charge	no charge	no charge	no charge	no charge
If you need immediate medical attention						
Online Care	$0	$0	$0	$0	$0	$0
Urgent Care	25% coinsurance	$14 copayment	$12 copayment	$20 copayment	$25 copayment (in-area) 20% coinsurance (out of area)	$15 copayment (in-area) 20% coinsurance (out of area)
Emergency Room	25% coinsurance	20% coinsurance	20% coinsurance	$100 copayment	$20% coinsurance	$100 copay worldwide
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 Visit	25% coinsurance	$14 copayment	$12 copayment	$20 copayment	$25 copay per visit	$15 copay per visit for adults 18+, no charge for children under 17
Specialist Visit	25% coinsurance	$14 copayment	$12 copayment	$20 copayment	$25 copay per visit	$15 copay per visit
Physical Therapy	25% coinsurance	20% coinsurance	20% coinsurance	$20 copayment	$25 copay per visit	$15 copay per visit
Radiology - General (e.g. X-ray, MRI,CT Scan, Ultrasound)	25% coinsurance	20% coinsurance	20% coinsurance	$10 copayment	20% coinsurance per dept/day	$15 copay per dept/day
Lab Tests (bloodwork)	25% coinsurance	$0	20% coinsurance	$10 copayment	20% coinsurance per dept/day	$15 copay per dept/day
Surgery (outpatient)	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$25 copayment	10% coinsurance

This summary is a brief description of benefits for comparison purposes only. Please refer to Plan Document for coverage details.

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Mental Health Services						
Inpatient Care	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$150 copay per day	10% coinsurance
Outpatient Care	25% coinsurance	$14 copayment	$12 copayment	$20 copayment	$25 copayment	$15 copayment
If you have a hospital stay (inpatient)						
Hospitalization/inpatient services	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$150 copay per day	10% coinsurance
If you're pregnant						
Routine Prenatal and Postnatal	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$0	No charge for routine labor and newborn
Delivery, Hospital Room & Board	25% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$150 copay per day	$0
Other coverages						
Drug Maximum Out of Pocket	Individual: $3,600 Family: $4,200	Individual: $3,600 Family: $4,200	Individual: $3,600 Family: $4,200	Individual: $3,600 Family: $4,200	Applies toward the maximum out of pocket limit	Applies toward the maximum out of pocket limit
Outpatient prescription drugs	$7 copayment: Tier 1 $30 copayment: Tier 2 $30 copayment plus $45 cost share: Tier 3 $100 copayment: Tier 4 $200 copayment: Tier 5	$7 copayment: Tier 1 $30 copayment: Tier 2 $30 copayment plus $45 cost share: Tier 3 $100 copayment: Tier 4 $200 copayment: Tier 5	$7 copayment: Tier 1 $30 copayment: Tier 2 $30 copayment plus $45 cost share: Tier 3 $100 copayment: Tier 4 $200 copayment: Tier 5	$7 copayment: Tier 1 $30 copayment: Tier 2 $30 copayment plus $45 cost share: Tier 3 $100 copayment: Tier 4 $200 copayment: Tier 5	$3 generic maintenance; $10 generic; $45 brand; $200 specialty	$3 generic maintenance; $10 generic; $45 brand; $200 specialty
Gym Membership Discount	See Active & Fit link https://www.hmsa.com/well-being/active-and-fit/	See Active & Fit link https://www.hmsa.com/well-being/active-and-fit/	See Active & Fit link https://www.hmsa.com/well-being/active-and-fit/	See Active & Fit link https://www.hmsa.com/well-being/active-and-fit/	$200 Gym/$10 Home Fitness	$200 Gym/$10 Home Fitness
Vision Exam	$10 copayment	$10 copayment	$10 copayment	$10 copayment	no charge	no charge
Eyeglasses and Contacts	$10 copayment (glasses) $25 copayment (contacts - up to $130 allowance)	$10 copayment (glasses) $25 copayment (contacts - up to $130 allowance)	$10 copayment (glasses) $25 copayment (contacts - up to $130 allowance)	$10 copayment (glasses) $25 copayment (contacts - up to $130 allowance)	$150 towards prescription eye glasses or contacts per calendar year	$150 towards prescription eye glasses or contacts per calendar year
Chiropractic Office Visits	n/a	$14 copayment services covered under medical plan after deductible met	$12 copayment services covered under medical plan after deductible met	$10 copayment* max number of visits per calendar year may apply	20 Visits @$20/Visit no referral needed - see link http://www.ashlink.com/ash/Kaiser HIC	20 Visits @$20/Visit no referral needed - see link http://www.ashlink.com/ash/Kaiser HIC
Alternative Medicine (Acupuncture, Massage Therapy, Naturopathy services)	n/a	n/a	n/a	n/a	20 Visits @$20/Visit no referral needed - see link http://www.ashlink.com/ash/Kaiser HIC	20 Visits @$20/Visit no referral needed - see link http://www.ashlink.com/ash/Kaiser HIC

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