RCUH Medical Insurance Summary: Plan Comparison: In-Network Coverages July 1, 2024 - June 30, 2025

	HMSA Comprehensive Medical Basic	HMSA Comprehensive Medical	HMSA Preferred Provider	HMSA HMO	Kaiser HMO Standard (Plan A)	Kaiser HMO Comprehensive (Plan B)	
Links to Full Plan Document and	<u>Plan Document</u>	<u>Plan Document</u>	<u>Plan Document</u>	<u>Plan Document</u>	<u>Plan Document</u>	<u>Plan Document</u>	
Summary of Benefits & Coverages (SBC)	SBC	SBC	SBC	<u>SBC</u>	SBC	SBC	
Plan Type	<u>Prefer</u>	red Provider Organ	<u>ization</u>	<u>Health</u>	Maintenance Organization		
In-Network	Blue Cross Blue Shield https://www.hmsa.com/search/providers/			HMSA Facility and Primary Care Physician (PCP)	Kaiser Permanente Hawaii https://healthy.kaiserpermanente.org/hawaii/doc tors-locations#/search-form		
Mainland Coverage		care: Blue Cross B	lue Shield	Out of network	Out of network *Additional coverage available for dependents outside service area		
Annual Deductible	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 (calendar year)	Individual: \$3,600 Family: \$4,200				Applies toward the maximum out of pocket limit		
Monthly Premium Cost (Employee cost only)	Single: \$258.09 2-Party: \$516.16 Family: \$903.64	Single: \$296.39 2-Party: \$592.74 Family: \$1,037.67	Single: \$375.36 2-Party: \$750.71 Family: \$1,314.14	Single: \$343.58 2-Party: \$687.16 Family: \$1,202.86	Single: \$199.33 2-Party: \$398.67 Family: \$697.67	Single: \$231.16 2-Party: \$462.32 Family: \$809.05	
To help maintain your health							
Annual Preventive Health Exam			no ch	narge			
If you need immediate medical attention		<u> </u>			T .	· .	
Urgent Care Emergency Room	25% coinsurance 25% coinsurance	\$14 copayment	\$12 copayment	\$20 copayment \$100 copayment	\$25 copayment 20% coinsurance	\$15 copayment \$100 copay	
Ambulance (ground or interisland air)	25% coinsurance			20% coinsurance	20% coinsurance		
If you visit a doctor or clinic (outpatient)							
Doctor or Specialist Visit (includes mental health)	25% coinsurance	\$14 copayment	\$12 copayment	\$20 copayment	\$25 copay per visit	\$15 copay per visit no charge for children under 17	
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	
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					T		
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		7 copayment (Tier 1); \$ Tier 3); \$100 copaymer	Refer to Drug Rider: \$3 generic maintenance; \$10 generic; \$45 brand; \$200 specialty				
Gym Membership Discount	Active & Fit Program				\$200 Gym/\$10 Home Fitness		
Vision Exam	\$10 copayment			no charge			
Chiropractic Office Visits	n/a	\$14 copayment	\$12 copayment	\$10 copayment	20 visits @ \$20/visit		
Alternative Medicine (Acupuncture, Massage Therapy, Naturopathy)	n/a			Refer to Kaiser CAMN+ flyer			

This summary is a brief description 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 exclusions.

RCUH Medical Insurance Summary: Plan Comparison – July 1, 2024 – June 30, 2025

Coverage EXAMPLES for Plan Comparison: Extracted from Summary of Benefits & Coverages (SBC) Documents: This is NOT a cost estimator. Treatments are just examples of how each plan might cover the medical care.

\$1,460

The total Peg would pay is

HMSA Comprehensive Med	ical Basic	HMSA Comprehensive M	ledical	HMSA Preferred Prov	ider
Peg is Having a Baby (9 months of in-network pre-natal care a delivery)		Peg is Having a Baby (9 months of in-network pre-natal care ar delivery)	nd a hospital	Peg is Having a Baby (9 months of in-network pre-natal care ar delivery)	nd a hospital
■ The <u>plan's</u> overall <u>deductible</u>	\$500	■ The <u>plan's</u> overall <u>deductible</u>	\$0	■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>coinsurance</u>	25%	■ <u>Specialist copayment</u>	\$14	■ Specialist copayment	\$12
■ Hospital (facility) <u>coinsurance</u>	25%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	10%
Other coinsurance	25%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes service Specialistoffice visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests(ultrasounds and blood of Specialist visit(anesthesia)		This EXAMPLE event includes service Specialistoffice visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests(ultrasounds and blood w Specialist visit(anesthesia)		This EXAMPLE event includes service: Specialistoffice visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests(ultrasounds and blood w Specialist visit(anesthesia)	
Total Example Cost	\$12,700	Total Example Cost	\$12,700	Total Example Cost	\$12,700
In this example, Peg would pay:		In this example, Peg would pay:		In this example, Peg would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$500	Deductibles	\$0	<u>Deductibles</u>	\$0
Copayments	\$10	Copayments	\$30	Copayments	\$20
Coinsurance	\$3,000	Coinsurance	\$2,000	Coinsurance	\$1,300
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions \$60		Limits or exclusions	\$60	Limits or exclusions \$6	
The total Peg would pay is	\$3,570	The total Peg would pay is	\$2,090	The total Peg would pay is	\$1,380
Peg is Having a Baby (9 months of in-network pre-natal care a delivery)		Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)	are and a	Peg is Having a Baby (9 months of in-network pre-natal of hospital delivery)	/ care and a
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$
■ Specialist copayment	\$20	Specialist copayment	\$25	Specialist copayment	\$1
■ Hospital (facility) coinsurance	10%	■ Hospital (facility) copayment	\$150	■ Hospital (facility) copayment	\$
Other coinsurance	20%	Other (blood work) coinsurance	20%	Other (blood work) <u>copayment</u>	\$1
This EXAMPLE event includes service Specialist office visits (prenatal care) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services	e s like:	This EXAMPLE event includes service Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	es	This EXAMPLE event includes serv Specialist office visits (prenatal care) Childbirth/Delivery Professional Servic Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and block Specialist visit (anesthesia)	ces
<u>Diagnostic tests</u> (ultrasounds and blood work) Specialist visit(anesthesia)		Total Example Cost	\$12,700	Total Example Cost	\$12,70
openius romanounous		In this example, Peg would pay:		In this example, Peg would pay:	
Total Example Cost	\$12,700	Cost Sharing	^	Cost Sharing	
		<u>Deductibles</u> Copayments	\$0 \$200	<u>Deductibles</u>	\$
n this example, Peg would pay:		Coinsurance	\$200	Copayments	\$2
Cost Sharing		What isn't covered	Ψ0	Coinsurance	
Deductibles	\$0	Limits or exclusions	\$0	What isn't covered Limits or exclusions	
	\$200	The total Peg would pay is	\$200	The total Peg would pay is	\$2
<u>Copayments</u>				The total Fog fround pay is	ų,
Coinsurance	\$1,200			1	
IA/lant lank access of					
What isn't covered	\$60				

RCUH Medical Insurance Summary: Plan Comparison – July 1, 2024 – June 30, 2025 Coverage EXAMPLES for Plan Comparison: Extracted from Summary of Benefits & Coverages (SBC) Documents:

This is NOT a cost estimator. Treatments are just examples of how each plan might cover the medical care.

HMSA Comprehensive Medical Basic		HMSA Comprehensive Medical		HMSA Preferred Provider	
Managing Joe's type 2 Diabe (a year of routine in-network care of a well condition)		Managing Joe's type 2 Dia (a year of routine in-network care of a v condition)		Managing Joe's type 2 Diab (a year of routine in-network care of a we condition)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist coinsurance	25%	■ Specialist copayment	\$14	■ Specialist copayment	\$12
■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	10%
■ Other <u>coinsurance</u>	25%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services Primary care physician office visits (includidisease education) Diagnostic tests(blood work) Prescription drugs Durable medical equipment(glucose meter	ng	This EXAMPLE event includes service Primary care physician office visits (includisease education) Diagnostic tests(blood work) Prescription drugs Durable medical equipment(glucose medical)	uding	This EXAMPLE event includes service Primary care physician office visits (includ disease education) Diagnostic tests(blood work) Prescription drugs Durable medical equipment(glucose meters)	ling
Total Example Cost	\$5,600	Total Example Cost	\$5,600	Total Example Cost	\$5,600
In this example, Joe would pay:		In this example, Joe would pay:		In this example, Joe would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$500	Deductibles	\$0	Deductibles	ėn.
Copayments	\$200	Copayments	\$400	Copayments	\$0 \$300
Coinsurance	\$400	Coinsurance	\$200		
What isn't covered	7.22	What isn't covered	4233	Coinsurance	\$200
Limits or exclusions	\$20	Limits or exclusions	\$20	What isn't covered	400
The total Joe would pay is	\$1,120	The total Joe would pay is	\$620	Limits or exclusions	\$20
LINACA LINAO				The total Joe would pay is	\$520 (Dlan D)
HMSA HMO		Kaiser HMO Standard (I	Plan A)	Kaiser HMO Comprehensive	(Plan B)
Managing Joe's type 2 Diabet (a year of routine in-network care of a well-o condition)		Managing Joe's Type 2 Dia (a year of routine in-network care controlled condition)	abetes of a well-	Managing Joe's Type 2 Dia (a year of routine in-network care of controlled condition)	betes If a well-
■ The <u>plan's</u> overall <u>deductible</u>	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ <u>Specialist copayment</u>	\$20	Specialist copayment	\$25	Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%	Hospital (facility) copayment	\$150		10%
Other coinsurance	20%	 Other (blood work) coinsurance 		 Hospital (facility) coinsurance Other (blood work) copayment 	\$15
This EXAMPLE event includes services I Primary care physicianoffice visits (including disease education) Diagnostic tests(blood work) Prescription drugs		Primary care physician office visits (ind disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose recognitions)	cluding neter)	This EXAMPLE event includes service Primary care physician office visits (includes as education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose medical)	luding
<u>Durable medical equipment(glucose meter)</u>		Total Example Cost	\$5,600	Total Example Cost	\$5,600
Total Evennie Cost	¢E coo	In this example, Joe would pay:		In this example, Joe would pay:	40,000
Total Example Cost	\$5,600	Cost Sharing Deductibles	\$0	Cost Sharing	
In this country is		Copayments	\$900	Deductibles	\$0
In this example, Joe would pay:		Coinsurance	\$200	Copayments	\$900
Cost Sharing	**	What isn't covered		Coinsurance	\$200
<u>Deductibles</u>	\$0	Limits or exclusions	\$0	What isn't covered	
<u>Copayments</u>	\$500	The total Joe would pay is	\$1,100	Limits or exclusions	\$0
Coinsurance	\$200			The total Joe would pay is	\$1,100
What isn't covered	400				
Limits or exclusions	\$20				
The total Joe would pay is	\$720				

RCUH Medical Insurance Summary: Plan Comparison – July 1, 2024 – June 30, 2025 Coverage EXAMPLES for Plan Comparison: Extracted from Summary of Benefits & Coverages (SBC) Documents:

This is NOT a cost estimator. Treatments are just examples of how each plan might cover the medical care.

HMSA Comprehensive Medical Basic		HMSA Comprehensive Medical		HMSA Preferred Provider		
Mia's Simple Fracture (in-network emergency room visit and follow up care)			Mia's Simple Fracture (in-network emergency room visit and follow up care)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	
■ Specialist coinsurance	25%	■ Specialist copayment	\$14	■ Specialist copayment	\$12	
	25%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	10%	
■ Hospital (facility) <u>coinsurance</u> ■ Other coinsurance	25%	■ Other <u>coinsurance</u>	20%	Other coinsurance	20%	
This EXAMPLE event includes servi Emergency room care(including medic supplies) Diagnostic test(x-ray) Durable medical equipment(crutches) Rehabilitation services(physical therap	cal	This EXAMPLE event includes serve Emergency room care (including medical supplies) Diagnostic test(x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therap	cal	This EXAMPLE event includes service Emergency room care(including medic supplies) Diagnostic test(x-ray) Durable medical equipment(crutches) Rehabilitation services(physical therap	al	
Total Example Cost	\$2,800	Total Example Cost	\$2,800	Total Example Cost	\$2,800	
In this example, Mia would pay:		In this example, Mia would pay:		In this example, Mia would pay:		
Cost Sharing		Cost Sharing	60	Cost Sharing		
Deductibles	\$500	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	
Copayments	\$10	Copayments	\$90	<u>Copayments</u>	\$70	
Coinsurance	\$600	Coinsurance	\$400	Coinsurance	\$400	
What isn't covered	\$000	What isn't covered		What isn't covered		
	**	Limits or exclusions	\$0	Limits or exclusions	\$0	
Limits or exclusions	\$0	The total Mia would pay is	\$490	The total Mia would pay is	\$470	
The total Mia would pay is HMSA HMO	\$1,110	Kaiser HMO Standard	(Plan A)	Kaiser HMO Comprehensi	ive (Plan B	
Mia's Simple Fracture (in-network emergency room visit and for care) The plan's overall deductible	\$0	Mia's Simple Fractor (in-network emergency room visit care) The plan's overall deductible	and follow up	Mia's Simple Fracti (in-network emergency room visit care) The plan's overall deductible	and follow up	
Specialist copayment	\$20	Specialist copayment	\$25	Specialist copayment	\$1	
■ Hospital (facility) <u>coinsurance</u>	10%	■ Hospital (facility) copayment ■ Other (x-ray) coinsurance	\$150 20%	 Hospital (facility) coinsurance Other (x-ray) copayment 		
Other coinsurance This EXAMPLE event includes service Emergency room care(including medical supplies) Diagnostic test(x-ray) Durable medical equipment(crutches)	20% s like:	This EXAMPLE event includes se Emergency room care (including me Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the	rvices like: edical supplies) es) rapy)	This EXAMPLE event includes se Emergency room care (including me Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the	edical supplies es)	
Rehabilitation services(physical therapy)		Total Example Cost	\$2,800	Total Example Cost	\$2,80	
Total Example Cost	\$2,800	In this example, Mia would pay:		In this example, Mia would pay:		
Total Example Cost	\$2,000	Cost Sharing	60	Cost Sharing		
		<u>Deductibles</u> Copayments	\$0 \$200	<u>Deductibles</u>	\$	
In this example, Mia would pay:		Coinsurance	\$400	Copayments	\$30	
Cost Sharing		What isn't covered	9700	Coinsurance What isn't covered	\$20	
<u>Deductibles</u>	\$0	Limits or exclusions	\$0	Limits or exclusions	9	
<u>Copayments</u>	\$200	The total Mia would pay is	\$600	The total Mia would pay is	\$50	
<u>Coinsurance</u>	\$300	• •		The total find froud pay to	400	
What isn't covered						
Limits or exclusions	\$0					
The total Mia would pay is	\$500					