Please refer to your Open Enrollment Notice to determine your plan offerings

2025 HMSA Hawaii PPO and Health Plan Hawaii HMO			
Services	**HMSA Preferred Provider Plan (PPO) In & Out-of-Network**		**Health Plan Hawaii Plus (HMO)**
	Member Pays *In-Network*	**Member Pays *Out-of-Network***	**Member Pays**
Annual Deductible (Individual / Family)	None	$100 / $300	None
Annual Out-of-Pocket Maximum (Individual / Family)	$2,500 / $7,500	$2,500 / $7,500	$2,500 / $7,500
Lifetime Maximum	None	None	None
Primary Care Physician Office	$12	30% after deductible	$20
In-Area Urgent Care	$12	30% after deductible	$20
Out-of-Area Urgent Care	$12	30% after deductible	$20
Primary Care Physician After	$12	30% after deductible	$20
Specialist Office Visit	$12	30% after deductible	$20
Virtual Visit	Online Care - No charge Telehealth- Benefit amounts vary depending on the type of service	Online Care- Not Covered Telehealth- Benefits amounts vary depending on the type of service	Online Care- No charge Telehealth- Benefit amounts vary depending on the type of service
Adult Physical Exam	Covered at 100% for members 22 years and older (one visit annually). Annual Preventive Health Evaluation is covered; please refer to the Guide to Benefits for more detail	30% after deductible for members 22 years and older (one visit annually). Annual Physical Health Evaluation is covered; please refer to the Guide to Benefits for more detail	Covered at 100%
OB/GYN Annual Exam	$0 for annual well woman exam; limited to one per calendar year	30% after deductible limited to one per calendar year	$0 limited to one per calendar year

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2025 HMSA Hawaii PPO and Health Plan Hawaii HMO			
Services	**HMSA Preferred Provider Plan (PPO) In & Out-of-Network**		**Health Plan Hawaii Plus (HMO)**
	Member Pays *In-Network*	**Member Pays *Out-of-Network***	**Member Pays**
Infertility Treatment	Regular plan benefits, more than one copay may apply limited to one IVF procedure per member per HMSA product; Precertification required; artificial insemination and services and supplies related to the diagnosis for infertility are covered 20% coinsurance	Regular plan benefits, more than one copay may apply limited to one IVF procedure per member per HMSA product; Precertification required; artificial insemination and services and supplies related to the diagnosis for infertility are covered 30% after deductible	20% limited to one IVF procedure per member per HMSA product; Plan approval required Artificial Insemination- $20
Maternity Care	10%	30% after deductible	10%
Child Wellness (through age 21)	$0	30%	$0
Emergency Room Visit	20%- Emergency Room $12- ER physician visit	20%- Emergency Room $12- ER physician visit	$100
Ambulance Service	20%	30% after deductible	20%
Inpatient Hospitalization	10%	30% after deductible	10%
Outpatient Hospitalization Surgery or Services	10% facility 10% professional charges cutting 20% professional charges non-cutting	30% after deductible	10% facility $20 professional charges
Pre-Admission Testing	20%	30% after deductible	20%
Second Surgical Opinion	$12	30% after deductible	$20
Hospitalization or Surgery	Precertification required for select services	Precertification required for select services	Precertification required for select services

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2025 HMSA Hawaii PPO and Health Plan Hawaii HMO			
Services	**HMSA Preferred Provider Plan (PPO) In & Out-of-Network**		**Health Plan Hawaii Plus (HMO)**
	Member Pays *In-Network*	**Member Pays *Out-of-Network***	**Member Pays**
Diagnostic Lab Test Imaging (CT/PET/MRI) X-ray Blood Work	10% inpatient 20% outpatient	30% after deductible	10% inpatient diagnostic lab or imaging 20% outpatient diagnostic lab or imaging 10% inpatient x-ray or blood work $10 outpatient x-ray or blood work
Anesthesia Service	10%	30% after deductible	10% inpatient; $20 outpatient
Speech, Occupational & Physical Therapy Visits	20% outpatient 10% inpatient Physical & Occupational - Certain services subject to precertification Speech – certain services subject to precertification	30% after deductible Physical & Occupational - Certain services subject to precertification Speech – certain service subject to precertification	$20 outpatient 10% inpatient Physical & Occupational - Certain services subject to precertification Speech – certain services subject to precertification
Spinal Manipulation / Chiropractic Visits	Covered Benefit amounts vary depending on the type of service	Covered Benefit amounts vary depending on the type of service	Covered Benefit amounts vary depending on the type of service
Durable Medical Equipment	20% Precertification or prescription from provider required	30% after deductible Precertification or prescription from provider required	20% Precertification or prescription from provider required
Routine Annual Eye Exam	$10 limited to one per calendar year	Difference between $35 plan allowance and provider charge	$20 limited to one per calendar year

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2025 HMSA Hawaii PPO and Health Plan Hawaii HMO			
Services	**HMSA Preferred Provider Plan (PPO) In & Out-of-Network**		**Health Plan Hawaii Plus (HMO)**
	Member Pays *In-Network*	**Member Pays *Out-of-Network***	**Member Pays**
Home Health Care	$0 limited to 150 visits per calendar year	30% after deductible limited to 150 visits per a calendar year	$0 limited to 365 visits per illness or injury
Extended Care Facility	10% Maximum 120 days per calendar year	30% after deductible Maximum 120 days per calendar year	10% Maximum 120 days per calendar year
Hospice Care	$0	Not covered	$0
Inpatient Mental Health and Substance Abuse	10%	30% after deductible	10%
Outpatient Mental Health Visits	$12 (physician services) 10% (hospital and facility services)	30% after deductible	$20
Allergy treatment	20%	30% after deductible	10%

Notes:

1. Copayments are shown with a dollar amount; e.g., $20.
2. Coinsurance is shown with a percentage amount; e.g., 10%.
3. For services requiring coinsurance, the Plan pays benefits after the member satisfies his/her annual deductible.
4. In-network services are based on HMSA contracted rate; Out-of-network services are based on Reasonable & Customary rate.
5. Out-of-pocket maximum includes copays, coinsurance and deductibles for medical claims; it does not include prescription drugs.
6. Air ambulance includes coverage for a one-way trip to the continental US when treatment is not available in Hawaii and air ambulance transportation to the continental US with life supporting equipment and/or a medical support team is needed.
7. Visit HMSA at www.hmsa.com or call 1-808-948-6111 or 1-800-776-4672.

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2025 Prescription Drug Benefits				
Plan	**Drug Tier**	**Drug Tier Description**	**Retail (30-Day Maximum Supply)**	**Mail Order (90-Day Maximum Supply)**
HMSA Preferred Provider Plan (PPO) In-Network	Tier 1	Generic Drugs	$7 100% covered for USPSTF recommended drugs	$11 (also applies to single-source generic drugs) 100% covered for USPSTF recommended drugs
	Tier 2	Mostly Preferred Drugs	$30 (also applies to single-source generic drugs) $100 for Specialty Drugs from a participating Specialty Pharmacy only	$65 Specialty Drugs not covered
	Tier 3	Mostly Other Brand Name Drugs	$30 + $45 other brand name cost share $200 for Specialty Drugs from a participating Specialty Pharmacy only	$65 + $135 other brand name cost share Specialty Drugs not covered
	Tier 4	Mostly Preferred Drugs	**Participating Pharmacy:** $100 copay **Non-Participating Pharmacy:** Not Covered	Not Covered
	Tier 5	Mostly Other Brand Name Drugs	**Participating Pharmacy:** $200 copay **Non-Participating** Pharmacy: Not Covered	Not Covered
HMSA Preferred Provider Plan (PPO) Out-of-network	Tier 1	Generic Drugs	$7 + 20% of remaining eligible charge	None
	Tier 2	Mostly Preferred Drugs	$30 + 20% of remaining eligible charge Specialty Drugs not covered	None

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2025 Prescription Drug Benefits				
Plan	**Drug Tier**	**Drug Tier Description**	**Retail (30-Day Maximum Supply)**	**Mail Order (90-Day Maximum Supply)**
	Tier 3	Mostly Other Brand Name Drugs	$30 + $45 other brand name cost share + 20% of remaining eligible charge Specialty Drugs not covered	None
	Tier 4	Mostly Preferred Drugs	Not Covered	Not Covered
	Tier 5	Mostly Other Brand Name Drugs	Not Covered	Not Covered
Health Plan Hawaii Plus (HMO)	Tier 1	Generic Drugs	**Participating Pharmacy:** $7 copay 100% covered for USPSTF recommended drugs **Non-Participating Pharmacy:** $7 copay + 20% of remaining eligible charge	**Participating Pharmacy:** $11 (also applies to single-source generic drugs) 100% covered for USPSTF recommended drugs **Non-Participating Pharmacy:** Not covered
	Tier 2	Mostly Preferred Drugs	**Participating Pharmacy:** $30 (also single-source generic drugs) $100 for Specialty Drugs from a participating Specialty Pharmacy only **Non-Participating Pharmacy:** $30 + 20% of remaining eligible charge Specialty Drugs not covered	**Participating Pharmacy:** $65 **Non-Participating Pharmacy:** Not covered

2025 Prescription Drug Benefits				
Plan	**Drug Tier**	**Drug Tier Description**	**Retail (30-Day Maximum Supply)**	**Mail Order (90-Day Maximum Supply)**
Health Plan Hawaii Plus (HMO)-con't	Tier 3	Mostly Other Brand Name Drugs	**Participating Pharmacy:** $30 + $45 other brand name cost share $200 for Specialty Drugs from a participating Specialty Pharmacy only **Non-Participating Pharmacy:** $30 +$45 other brand name cost sharing + 20% of remaining eligible charge Specialty Drugs not covered	**Participating Pharmacy:** $65 + $135 other brand name cost share **Non-Participating Pharmacy:** Not covered
	Tier 4	Mostly Preferred Drugs	**Participating Pharmacy:** $100 copay **Non-Participating Pharmacy:** Not Covered	Not Covered
	Tier 5	Mostly Other Brand Name Drugs	**Participating Pharmacy:** $200 copay **Non-Participating** Pharmacy: Not Covered	Not Covered
Out-of-Pocket Maximum Prescription drug annual out-of-pocket maximum is $3,600 per member, $4,200 per family.				

Notes:

1. Some preventive medications have a $0 copay as required by the Affordable Care Act (ACA).
2. If you choose a brand name drug when a generic drug is available, you will be assessed a Dispense as Written (DAW) penalty, which is the generic copay plus the difference between the cost of the brand-name drug and the generic drug.
3. You will pay the mail order copay if you fill a prescription more than three times (initial prescription plus two refills) at a retail pharmacy.
4. U.S. Preventive Services Task Force (USPSTF). Contact HMSA for a list of USPSTF recommended drugs.
5. Visit HMSA at www.hmsa.com or call 1-808-948-6111.

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2025 Cigna Dental Plans				
	Cigna Standard DPPO Plan		Cigna Enhanced DPPO Plan	
Plan Design Attribute	**Cigna PPO Dentists**	**Non-PPO Dentists**	**Cigna PPO Dentists**	**Non-PPO Dentists**
Annual Deductible	$50/$150	$50/$150	$50/$150	$50/$150
Annual Maximum	$1,500	$1,500	$2,000	$2,000
Diagnostic & Preventive Services Exams (2 per calendar year) and cleanings (2 per calendar year in the Standard Plan, 4 cleanings per calendar year in the Enhanced plan), prophylaxis, including scaling and polishing; fluoride treatments, sealants & space maintainers to age 16; x-rays and lab tests; tests for pulp vitality; palliative emergency treatment	100%	100%	100%	100%
Amalgam and Posterior Composite Restorations	80%	80%	100%	100%
Basic Services Denture repair/relining, recommendation of crowns, bridges, facings and inlays	80%	80%	80%	80%
Endodontics (root canals) **Periodontics** (gum treatment) **Oral Surgery & Anesthesia Extractions**	80%	80%	80%	80%
Oral Surgery (bony extractions)	100%	100%	100%	100%
Major Services Crowns, inlays, onlays and cast restorations **Prosthodontics** Bridges, dentures and implants	50%	50%	50%	50%
Orthodontia Benefits	50%	50%	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000	$1,500	$1,500

Notes:

1. Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.
2. Reimbursement is based on the PPO contracted fees for PPO dentists, Premier contracted rates for Premier dentists and 80th percentile for non-Cigna dentists.
3. Visit Cigna at www.mycigna.com or call 1-833-55GEICO.

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2025 Kaiser Hawaii		
Services	**Member Pays** ***In-Network***	**Member Pays** ***Out-Of-Network***
Annual Deductible (Individual / Family)	None	$100 / $300
Annual Out-of-Pocket Maximum (Individual / Family)	$2,000 / $6,000	$2,000 / $6,000
Lifetime Maximum	None	None
Primary Care Physician Office Visits	$15/visit	20% after deductible
In-Area Urgent Care	$15/visit at a Kaiser Permanente facility within the Hawaii service area	20% at a Kaiser Permanente facility within the Hawaii service area
Out-of-Area Urgent Care	20% at a non-Kaiser Permanente facility outside the Hawaii service area	20% after deductible at a non-Kaiser Permanente facility outside the Hawaii service area
Primary Care Physician After Hours Visits	$15/visit	20% after deductible
Specialist Office Visit	$15/visit	20% after deductible
Virtual Visits	No charge	No charge
Adult Physical Exam	$0/visit	20%, deductible does not apply
OB/GYN Annual Exam	$0/visit	20%, deductible does not apply
Infertility Treatment	$15/visit; 20% Coins for IVF limited to 1 cycle per lifetime. Includes Infertility Drugs	20% after deductible; includes IVF limited to 1 cycle per lifetime. Includes Infertility Drugs
Maternity Care	$0/visit after confirmation of pregnancy	20% after deductible
Child Wellness (up to age 18)	$0/visit	20%, deductible does not apply
Emergency Room Visit	$75/visit waived if admitted	$75/visit waived if admitted
Ambulance Service	20%	20% after deductible
Inpatient Hospitalization*	$50/day	20% after deductible
Outpatient Hospitalization Surgery or Services	$15/procedure	20% after deductible
Pre-Admission Testing	$0/procedure	20% after deductible
Second Surgical Opinion	$15/visit	20% after deductible
Hospitalization or Surgery	Precertification required	20% after deductible
Diagnostic Lab Test/X-rays	$0/procedure	20% after deductible
Anesthesia Service	$0	20% after deductible

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2025 Kaiser Hawaii		
Services	**Member Pays** ***In-Network***	**Member Pays** ***Out-Of-Network***
Speech, Occupational & Physical Therapy Visits	$15/visit Limited to certain clinical criteria and Kaiser Permanente physician determination	20% after deductible
Spinal Manipulation / Chiropractic Visits	Not covered	Not covered
Durable Medical Equipment	20%	20% after deductible
Routine Annual Eye Exam	$15/visit	20% after deductible
Home Health Care	$0/visit	20% after deductible limited to a combined benefit maximum of 150 visits per calendar year
Skilled Nursing Facility	$0/admit Maximum 120 days per accumulation period	20% after deductible Limited to a combined benefit maximum of 120 days per calendar year
Hospice Care	$0/service	20% after deductible Limited to a combined benefit maximum of 210 days while insured
Inpatient Mental Health and Substance Abuse	$50/day	20% after deductible
Outpatient Mental Health Visits	$15/visit	20% after deductible
Allergy treatment	$15/test visit Testing covered 100%	20% after deductible
Optical 150	All costs greater than a $150 allowance per calendar year. When optical prescription is filled at a Kaiser Permanente Hawaii optical center, the allowance may be used for prescription glasses lenses/frames/lens treatment OR prescription contact lens/contact lens exam	Pediatric: $50 total allowance for lenses, frames, and contacts for out-of-network providers

* Inpatient Hospital benefit shown as a per admission copay unless otherwise specified.

1. Copayments are shown with a dollar amount; e.g., $20.
2. Coinsurance is shown with a percentage amount; e.g., 10%.
3. For services requiring coinsurance, the Plan pays benefits after the member satisfies his/her annual deductible.
4. In-network services are based on HMO contracted rate; Out-of-network services are based on Reasonable & Customary rate.

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5. Out-of-pocket maximum includes copays, coinsurance and deductibles for medical claims; it does include prescription drugs.
6. Laboratory tests and x-rays conducted while a patient is hospitalized are included in the inpatient hospitalization copay.
7. Visit Kaiser Hawaii at http://my.kp.org/geico or call 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) for member services, or our pre-enrollment line at 1-800-514-0985 (TTY 711), Monday to Friday, 7 a.m. to 6 p.m. Pacific time.

2025 Kaiser Hawaii Prescription Drug Benefit			
Drug Tier	**Drug Tier Description**	**Retail (30-Consecutive Day Supply or Amount Determined by Formulary)**	**Mail Order (90-Consecutive Day Supply or Amount Determined by Formulary)**
Tier 1	Generic drugs	$3 in-network at KP Pharmacy 20% at contracted pharmacies (but not less than $3)	$6 in-network through KP Mail Order Service Not covered out-of-network
Tier 2	Preferred brand-name drugs	$10 in-network at KP Pharmacy 20% at contracted pharmacies (but not less than $10)	$20 in-network through KP Mail Order Service Not covered out-of-network
Tier 3	Non-preferred brand-name drugs	$35 in-network at KP Pharmacy 20% at contracted pharmacies (but not less than $35)	$70 in-network through KP Mail Order Service Not covered out-of-network
Tier 4	Specialty drugs	$200 in-network at KP Pharmacy 20% at contracted pharmacies (but not less than $200)	Not applicable Not covered out-of-network
Prescription drugs are included in the medical out-of-pocket maximum.			

1. Some preventive medications have a $0 copay as required by the Affordable Care Act (ACA).
2. Visit Kaiser Hawaii at http://my.kp.org/geico or call 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) for member services, or our pre-enrollment line at 1-800-514-0985 (TTY 711), Monday to Friday, 7 a.m. to 6 p.m. Pacific time.

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2025 EyeMed Vision Care		
Standard		
Services	**In-Network**	**Out-of-Network**
Exam, With Dilation as Necessary *Once every calendar year*	No copay	Up to $40
Frames *Once every calendar year*	No copay; $175 allowance; 20% off balance over $175	Up to $105
Contact Lenses (in lieu of Lens benefit)		
Conventional	No copay; $175 allowance; 15% off remaining balance	Up to $125
Disposable	No copay; $175 allowance, plus balance over $175	Up to $125
Medically necessary	No copay; Paid in full	Up to $300
Standard Plastic Lenses		
Single	$25 copay	Up to $40
Bifocal	$25 copay	Up to $60
Trifocal	$25 copay	Up to $100
Standard Progressive Lenses	$75 copay	Up to $85
Premium Progressive Lenses:		
Tier 1	$95 copay	Up to $85
Tier 2	$105 copay	Up to $85
Tier 3	$120 copay	Up to $85
Tier 4	$75 copay; 20% off retail price less $120 allowance	Up to $85
Lenticular	$25 copay	Up to $100
Retinal Imaging	Up to $39	NA
Laser Vision Correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	NA
Extra Pairs Discount *Must be only following the use of the funded benefit*	40% off additional complete frames 15% off conventional contact lenses	NA
Contact Lens Fit and Follow-up		
Standard Contact Lens	Up to $40	N/A
Premium Contact Lens	10% off retail	N/A
Available only following a comprehensive eye exam		
Frequency Exam, Lenses or Contact Lenses, Frames	Once each calendar year per service	

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<table>
<tr><th colspan="4">2025 EyeMed Vision Care</th></tr>
<tr><th colspan="4">Enhanced</th></tr>
<tr><th>Services</th><th>PLUS Providers</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Exam, With Dilation as Necessary
Once every calendar year</td><td>No copay</td><td>No copay</td><td>Up to $40</td></tr>
<tr><td>Frames
Once every calendar year</td><td>No copay; $225 allowance;
20% off balance over $225</td><td>No copay; $175 allowance;
20% off balance over $175</td><td>Up to $105</td></tr>
<tr><td>Contact Lenses
(in lieu of Lens benefit)
Conventional
Disposable
Medically necessary</td><td>No copay; $225 allowance; 15% off remaining balance
No copay; $225 allowance, plus balance over $225
No copay; Paid in full</td><td>No copay; $175 allowance; 15% off remaining balance
No copay; $175 allowance, plus balance over $175
No copay; Paid in full</td><td>Up to $125
Up to $125
Up to $300</td></tr>
<tr><td>Standard Plastic Lenses
Single
Bifocal
Trifocal

Standard Progressive Lenses

Premium Progressive Lenses:
Tier 1
Tier 2
Tier 3
Tier 4

Lenticular</td><td colspan="2">No copay
No copay
No copay

$50 copay

$70 copay
$80 copay
$95 copay
$215 copay

No copay</td><td>Up to $40
Up to $60
Up to $100

Up to $85

Up to $85
Up to $85
Up to $85
Up to $85

Up to $100</td></tr>
<tr><td>Retinal Imaging</td><td colspan="2">Up to $39</td><td>NA</td></tr>
<tr><td>Laser Vision Correction
LASIK or PRK from U.S. Laser</td><td colspan="2">15% off retail price or 5% off promotional price</td><td>NA</td></tr>
<tr><td>Extra Pairs Discount
Must be only following the use of the funded benefit</td><td colspan="2">40% off additional complete frames
15% off conventional contact lenses</td><td>NA</td></tr>
<tr><td>Additional Glasses Allowance
Valid once every plan year</td><td>No copay; $100 allowance</td><td>No copay; $50 allowance</td><td>Up to $40</td></tr>
<tr><td>Contact Lens Fit and Follow-up
Standard Contact Lens
Premium Contact Lens
Available only following a comprehensive eye exam</td><td colspan="2">Up to $40
10% off retail</td><td>Up to $40</td></tr>
</table>

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Frequency Exam, Lenses or Contact Lenses,	Once each calendar year per service

Visit EyeMed at www.eyemed.com or call 1-844-434-2636.