HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Option Plus *one*

Medical Plan Schedule of Benefits 2026

Annual Deductible $100 per person / $300 maximum per family

Out-of-Pocket Maximum (per calendar year, includes deductibles and copayments)

Participating Provider $600 per person / $1,800 per family

Non-Participating Provider $1,100 per person / $3,300 per family

Lifetime Maximum Unlimited

Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Hospital and Facility Services		
Ambulatory Surgical Center (ASC)	10%	20%
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Facilities)	10%	$200 (per first confinement in calendar year) + 20%*
Hospital Ancillary Services	10%	20%*
Hospital Room and Board	10%	$200 (per first confinement in calendar year) + 20%*
Outpatient Facility	10%	20%
Emergency Services and Urgent Care		
Emergency Room	10%	10%
Physician Visits	10%	10%
Urgent Care	$25	$50
Physician Services		
Physician Visits	10%	$10 + 20%
Hospital Visits	10%	$10 + 20%
Immunizations (standard, including travel)	None	30%
Online and Telephonic Care via HMAA's HiDoc® Service	None	Not Covered
Telehealth Services	Your deductible and copayment/coinsurance amounts vary depending on the type of service or supply. See copayment/coinsurance amounts listed in this chart for the service or supply you receive.	
Testing, Laboratory and Radiology		
Allergy Testing	$15 + 10%*	$25 + 20%*
Allergy Treatment Materials	$15 + 10%*	$25 + 20%*
Diagnostic Testing	10%	20%*
Laboratory and Pathology	10%	20%*
Radiology	10%	20%*
Chemotherapy and Radiation Therapy		
Chemotherapy — Infusion/Injections	10%*	20%*
Radiation Therapy	10%	20%*
Other Medical Services and Supplies		
Acupuncture, Chiropractic, Massage, and Naturopathic Services	10%	20%*
Ambulance (air or ground)	20%*	20%*
Blood and Blood Products	10%*	20%*
Dialysis and Supplies	10%*	20%*
Durable Medical Equipment and Supplies	10%*	20%*
Evaluations for Hearing Aids	10%*	20%*
Growth Hormone Therapy	10%*	20%*
Home IV Therapy	$5 + 10%	30%
Inhalation Therapy	10%*	20%*
Injections	10%*	20%*
Medical Foods	10%	20%
Orthotics and External Prosthetics	10%*	20%*
Vision and Hearing Appliances	10%*	20%*

* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

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Benefit	Coinsurance/Copayment	
	Participating	Non-Participating
Rehabilitation Therapy		
Physical and Occupational Therapy		
Inpatient	10%	20%*
Outpatient	$5 + 10%*	30%*
Speech Therapy Services		
Inpatient	10%	20%*
Outpatient	$5 + 10%*	30%*
Special Benefits – Disease Management and Preventive Services		
Disease Management	None	Not Covered
Preventive Services — Laboratory	None	20%*
Preventive Services — Physical Exam	None	$10 + 20%*
Screening and Preventive Counseling	None	20%*
Special Benefits for Children		
Newborn Care	10%	20%*
Well Child Care Immunizations	None	None
Well Child Care Laboratory Tests	None	20%
Well Child Care Physician Office Visits	None	$10 + 20%
Special Benefits for Men		
Prostate Specific Antigen Test (screening)	10%	20%
Special Benefits for Women		
Breast Pump	None	None
Chlamydia Screening	None	20%*
Contraceptive Implants (generic)	None	30%
Contraceptive Injectables (generic)	None	30%
Contraceptive IUD (generic)	None	30%
In Vitro Fertilization	10%	20%
Mammography (screening)	None	20%
Maternity Care	10%	20%*
Pap Smears (screening)	None	20%
Pregnancy Termination	10%	20%
Tubal Ligation	None	20%
Well Woman Exam	None	20%
Special Benefits for Homebound, Terminal, or Long-Term Care		
Home Health Care	None	30%
Hospice Services	None	None*
Behavioral Health – Mental Health and Substance Abuse		
Hospital and Facility Services		
Inpatient	10%	$200 (per first confinement in calendar year) + 20%*
Outpatient	10%	20%
Physician Services		
Inpatient	10%	20%*
Outpatient	10%	$10 + 20%
Psychological Testing	10%	20%*

Special Offers	
Employee Assistance Program (EAP)	Up to 6 fully-covered visits to assist subscribers with personal or family issues
Health and Wellness Programs	A variety of solutions for healthy living including Active&Fit®, Flu Prevention, Colorectal Cancer Screening, Baby & Me (our free maternity incentive program), and more
Member Plus Discount Program	Discounted prices and special offers from HMAA member groups and other participating merchants

The Active&Fit and Active&Fit Direct programs are provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct, Active&Fit Connected!, Active&Fit, and the Active&Fit Direct logos are trademarks of ASH and used with permission herein.

* = Annual Deductible Applies | % = Coinsurance (Percentage based on eligible charge) | $ = Copayment (Fixed dollar amount)

Note: Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods. This document is intended to provide a condensed explanation of benefits. Please refer to the Description of Coverage (DOC) for details. In the case of a discrepancy between this document and the language contained within the DOC, the latter will take precedence.

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Dental Plan B
Schedule of Benefits

Benefit	Plan Pays
Annual Maximum	**$1,000**
Basic Services	**100%**
• Oral Exams (twice per calendar year)	
• Bitewing X-rays (twice per calendar year)	
• Full Mouth X-rays (once per 3 calendar years)	
Preventive Services	**70%**
• Cleanings (twice per calendar year)	
• Fluoride Treatments (twice per calendar year through age 17)	
• All Other X-rays (as required)	
Restorative Services	**70%**
• Restorative Treatment	
• Palliative Treatment	
• Oral Surgery	
• Endodontics	
• Periodontics	
Major Services*	**50%**
• Crowns **	
• Bridges and Dentures ** (repairs and adjustments)	

*** Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.**

**** Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.**

Note: The above reimbursement percentages are based on participating provider negotiated charges. If you go to a non-participating dental provider, benefits will be calculated on a lower eligible charge. The member is responsible for paying any remaining balance over the eligible charge up to the full billed amount. Exclusions and limitations apply. This document is intended to provide a condensed explanation of benefits. Please refer to the Dental Plan documents for details. In the case of a discrepancy between this document and the language contained within the Dental Plan documents, the latter will take precedence.

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Dental Plan B
$1,000 Annual Maximum

Please read the following material thoroughly for a description of your HMAA dental plan. Your member ID card will specify the dental plan in which you are enrolled.

Benefits

BASIC SERVICES / PREVENTIVE SERVICES:

- Routine Oral Examinations: twice per calendar year.
- Bitewing X-Rays: twice per calendar year.
- Panoramic Full Mouth X-Rays: once per 3 calendar years.
- Cleanings: twice per calendar year.
- Fluoride Treatments: twice per calendar year through age 17.
- All Other X-rays for preventive services: as required.

RESTORATIVE SERVICES:

- Office visits and Palliative Treatments.
- Amalgam Fillings (excluding gold)
- Fillings using composite resin (for anterior teeth only)
- Endodontics: Root Canal Therapy, Apicoectomies and Root Resection.
- Periodontics: Gingival curettage, once every 2 years; Osseous Surgery and Gingivectomies: once every 3 years.
- Following the completion of active Periodontal Surgery (which includes 6 months of follow-up care), 3 Prophylaxis treatments are allowed within the next 12-month period.
- Oral Surgery: Simple Extractions, Surgical Extractions of erupted or impacted teeth, and other Oral Surgical procedures.
- General anesthesia and intravenous sedation when medically necessary.

MAJOR SERVICES*:

- Crowns, Crown build-ups (when teeth cannot be restored with fillings): once every 5 years for the same tooth.**
- Complete Dentures, Partial Dentures (acrylic and cast chrome), Bridges: once every 5 years.**
- Complete and Partial Denture repairs and adjustments: twice per calendar year.

Pre-Determination of Benefits

HMAA recommends that the plan of treatment proposed by your dentist be approved by HMAA before treatment begins; however, in cases of emergency or brief routine procedures in which the total fee does not exceed $300, a treatment form need not be submitted before the dental services are performed.

Coordination of Benefits

The Plan will coordinate dual coverage for you by sharing the Dental expenses you might incur with the other plan.

Limitations

BENEFITS SHALL NOT BE PAYABLE FOR:

- **Any major services performed during the first year of continuous enrollment.**
- Taxes, broken appointments, completion of claim forms, oral hygiene or dietary instruction, plaque control programs, lost, stolen or damaged dentures or dental appliances, and incomplete dental treatments.
- Services started prior to the effective date of coverage and/or services started after termination of coverage date.
- Services relating to work-related injuries and automobile- related injuries or when the patient is not financially responsible.
- Desensitizing treatments, sealants, fixed bridgework or dentures for children under age 16, porcelain or plastic veneers placed for cosmetic reasons (including congenital malformations), porcelain crowns posterior to the second bicuspid, precision attachments for partial dentures, gold fillings and gold inlays.
- Composite restorations in posterior teeth (primary and permanent).
- Orthodontic services (including extraction of teeth in preparation of orthodontia).
- Experimental and/or investigational dental services; procedures, appliances, or restorations other than those for replacement of structure loss for caries, that are medically necessary to alter, restore or maintain occlusion. Such procedures include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, restorations for tooth malalignment, gnathological rescorings, and treatments of disturbances of the temporomandibular joint.
- Services with respect to medically-related problems, congenital malformations, or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia.
- Hospitalization, including any emergency room visits, unless in conjunction with an authorized oral surgery procedure for treatment of fractures or dislocations.
- Implants or specialized technique to include, but not limited to, bone grafting, guided tissue regeneration, locally administered antibiotics or enzyme therapies and any other procedure that may be experimental in nature.
- Dental care rendered by a dentist or other licensed dental care professional beyond the scope of his license, or by unlicensed persons.
- When alternate treatments are available, The Plan will cover the most economical course of treatment. The patient is responsible for any difference in charges to upgrade the treatment.
- Charges in excess of participating provider's negotiated fees. The Plan has the exclusive right to determine eligible fees for Non-Participating Providers.

*** Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.**

**** Replacements are covered if the existing crown, bridge, or denture is at least 5 years old.**

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Vision Plus Plan

Schedule of Benefits

Benefits	Plan Pays	
	Participating & Affiliate Provider*	Non-Participating Provider
Examinations		
• Vision Exam	100% after $25 copay	up to $45
Prescription Glasses (instead of contacts)		
• Frame	100% after $25 copay for Frames up to $120 or Featured Frame Brands up to $140 (up to $65 at Costco**)	up to $70
	20% off the amount over your allowance	
• Lenses		
Single Vision Lenses	100%	up to $30
Lined Bifocal Lenses	100%	up to $50
Lined Trifocal Lenses	100%	up to $65
Note: Polycarbonate lenses for dependent children		
• Lens Enhancements		
Standard Progressive Lenses	100%	up to $50
Premium Progressive Lenses	100% after copay ranging from $95 to $105	up to $50
Custom Progressive Lenses	100% after copay ranging from $150 to $175	up to $50
Contacts (instead of glasses)	$120	up to $105
• Contact Lens Exam (fitting and evaluation)	100% after copay up to $60	

Frequency of Services

• Examination	Once every 12 months
• Prescription Glasses	
Frame	Once every 24 months
Lenses	Once every 24 months
Lens Enhancements	Once every 24 months
• Contacts	Once every 24 months

Vision plans are underwritten by Vision Service Plan (VSP)

* Participating Provider network is VSP Choice. Your coverage with a retail chain affiliate provider may be different from the coverage with a Participating Provider.

** Applies to Oahu and participating Neighbor Island Costco Optical locations.

This is a summary of benefits effective January 1, 2024. Please refer to VSP for details.

A Look at your VSP Vision Coverage

With VSP and HMAA Vision Plus Plan, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP® network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

PROVIDER NETWORK:

VSP Choice

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

vsp vision care

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$25 Up to $39
PRESCRIPTION GLASSES		**$25**
FRAME+	• $120 Frame allowance • $140 Featured Frame Brands allowance • 20% savings on the amount over your allowance • $65 Costco frame allowance • Every 24 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 24 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 24 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

COVERAGE WITH AN OUT-OF-NETWORK PROVIDER

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $45
Frame ..... up to $70
Single Vision Lenses ..... up to $30
Lined Bifocal Lenses ..... up to $50
Lined Trifocal Lenses ..... up to $65
Progressive Lenses ..... up to $50
Contacts ..... up to $105

Create an account today.

Contact us at:
800.877.7195 or **vsp.com**

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.