

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hmsa.com.

For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary/> or call 1-800-776-4672 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| <p>What is the overall deductible?</p> | <p>\$100 individual / \$300 family</p> | <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Certain preventive care and well-child care services will be covered before you meet your deductible.</p> | <p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>\$2,500 individual / \$7,500 family (applies to medical plan coverage). \$1,100 individual / \$1,650 employee + spouse / \$2,200 family (applies to prescription drug coverage).</p> | <p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billed charges, prescription drug copayments, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of network providers.</p> | <p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider (unless otherwise defined by federal law), and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see the specialist you choose without a referral.</p> |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Specialist visit | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Other practitioner office visit: | | | |
| | Physical and Occupational Therapist | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Psychologist | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Nurse Practitioner | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Preventive care (Well Child Physician Visit) | No charge; deductible does not apply | 30% coinsurance ; deductible does not apply | Age and frequency limitations may apply. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. |
| | Screening | | | |
| | Colonoscopy Screening | No charge; deductible does not apply | 30% coinsurance | Coverage is provided in accordance with HMSA's medical policies |
| | Mammography Screening | No charge; deductible does not apply | 30% coinsurance ; deductible does not apply | For age 40 and over, limited to one Screening per calendar year. |
| | Pap Smears Screening | No charge; deductible does not apply | 30% coinsurance | Limited to one every three years for women ages 21 to 65. |
| | Prostate Specific Antigen Test Screening | 20% coinsurance ; deductible does not apply | 30% coinsurance | 1 Service per Calendar Year 50 Years of Age and Above |
| | Sigmoidoscopy Screening | No charge; deductible does not apply | 30% coinsurance | Coverage is provided in accordance with HMSA's medical policies |
| Immunization (Standard) | No charge; deductible does not apply | 30% coinsurance | ---none--- | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a test | <u>Diagnostic test</u> | | | |
| | Inpatient | 10% coinsurance ; deductible does not apply | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance ; deductible does not apply | 30% coinsurance | |
| | X-ray | | | |
| | Inpatient | 10% coinsurance ; deductible does not apply | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance ; deductible does not apply | 30% coinsurance | |
| | Blood Work | | | |
| | Inpatient | 10% coinsurance ; deductible does not apply | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance ; deductible does not apply | 30% coinsurance | |
| | Imaging (CT/PET scans, MRIs) | | | |
| | Inpatient | 10% coinsurance ; deductible does not apply | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance ; deductible does not apply | 30% coinsurance | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com or 1-888-402-1984. | Generic drugs (retail) | \$10 copay ; deductible does not apply | Not covered | Covers up to a 90-day supply at in-network pharmacies, if applicable, with multiple copays. Separate prescription drug out-of-pocket maximum: \$1,100 person/\$1,650 employee + spouse or employee + child(ren)/ \$2,200 family |
| | Generic drugs (mail order) | \$10 copay ; deductible does not apply | Not covered | |
| | Preferred Formulary Drugs (retail) | 20% coinsurance (\$20 min, \$75 max copay/30-day supply); deductible does not apply | Not covered | |
| | Preferred Formulary Drugs (mail order) | 20% coinsurance (\$20 min, \$75 max copay/30-day supply); deductible does not apply | Not covered | |
| | Non-preferred Formulary Drugs (retail) | 40% coinsurance (\$40 min, \$100 max copay/30-day supply) ; deductible does not apply | Not covered | |
| | Non-preferred Formulary Drugs (mail order) | 40% coinsurance (\$40 min, \$100 max copay/ 30-day supply); deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Specialty drugs (retail) | Covered as listed above | Not covered | Coverage may include limitations and preauthorization may be required. |
| | Specialty drugs (mail order) | Covered as listed above | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Physician Visits | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Surgeon fees | 10% coinsurance ; deductible does not apply (cutting) | 30% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance ; deductible does not apply (non-cutting) | 30% coinsurance (non-cutting) | ---none--- |
| If you need immediate medical attention | Emergency room care | | | |
| | Physician Visit | 10% coinsurance ; deductible does not apply | 10% coinsurance ; deductible does not apply | ---none--- |
| | Emergency room | 10% coinsurance ; deductible does not apply | 10% coinsurance ; deductible does not apply | ---none--- |
| | Emergency medical transportation (air) | 20% coinsurance | 20% coinsurance | Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental US is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply. |
| | Emergency medical transportation (ground) | 20% coinsurance | 30% coinsurance | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | Urgent care | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Physician Visits | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Surgeon fee | 10% coinsurance ; deductible does not apply (cutting) | 30% coinsurance (cutting) | ---none--- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Surgeon fee | 20% coinsurance ; deductible does not apply (non-cutting) | 30% coinsurance (non-cutting) | ---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | | | |
| | Physician services | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Hospital and facility services | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Inpatient services | | | |
| | Physician services | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| | Hospital and facility services | 10% coinsurance ; deductible does not apply | 30% coinsurance | ---none--- |
| If you are pregnant | Office visit (Prenatal and postnatal care) | 10% coinsurance ; deductible does not apply | 30% coinsurance | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance ; deductible does not apply | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance ; deductible does not apply | 30% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | No charge; deductible does not apply | 30% coinsurance | 150 Visits per Calendar Year |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |
| | Skilled nursing care | 10% coinsurance ; deductible does not apply | 30% coinsurance | 120 Days per Calendar Year. Includes extended care facilities (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) to the extent care is for Skilled nursing care , sub-acute care, or long-term acute care. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Hospice services | No charge; deductible does not apply | Not covered | ---none--- |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Excluded service |
| | Children's glasses (single vision lenses and frames selected within designated group) | Not covered | Not covered | Excluded service |
| | Children's dental check-up | Not covered | Not covered | Excluded service |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

| | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture Cardiac rehabilitation Chiropractic care (e.g. hot/cold application, laser therapy) Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Dental care (Child) Habilitation services Long-term care | <ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult) Routine eye care (Child) Routine foot care Weight loss programs |
|---|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

| | |
|---|---|
| <ul style="list-style-type: none"> Bariatric surgery Hearing aids (limited to one hearing aid per ear every 60 months) Infertility Treatment (Artificial Insemination and In Vitro Fertilization. Please refer to your plan document for limitations and additional details) | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. For more information, see www.hmsa.com |
|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1) 1-800-776-4672 for HMSA; 2) (808) 586-2790 for the State of Hawaii, Dept. of Commerce and Consumer Affairs – Insurance Division; 3) 1-866-444-3272 or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act> for the U.S. Department of Labor, Employee Benefits Security Administration; or 4) 1-877-267-2323 x61565 or <http://www.cciio.cms.gov> for the U.S. Department of Health and Human Services. Church plans are not covered by the Federal COBRA continuation coverage rules. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit <http://www.HealthCare.gov> or call 1-800-318-2596. contact:

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, you must submit a written request for an [appeal](#) to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about [appeals](#), you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act>. You may also file a [grievance](#) with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.
- For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an [appeal](#) to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about [appeals](#), you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a [grievance](#) with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

Does this Coverage Provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-776-4672.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-------|
| ■ The plan's overall deductible | \$100 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$100 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$100 |
| ■ Specialist coinsurance | 10% |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$10 |
| Coinsurance | \$1,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,470 |

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$300 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$720 |

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$10 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$510 |