

 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 www.healthcare.gov/sbc-glossary/ or call 1-800-776-4672 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not Applicable.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes. \$2,500 individual / \$7,500 family (applies to medical <u>plan</u> coverage). \$3,600 individual / \$4,200 family (applies to <u>prescription drug coverage</u>).	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed charges</u> , payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your <u>copayment</u> for covered services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of <u>network providers</u> . For alcoholism or chemical dependency <u>providers</u> , call the Assistance Recovery Program (ARP) at (800) 562-3277.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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	\$14 <u>copay</u> /visit	\$14 <u>copay</u> /visit	None.
	<u>Specialist visit</u>	\$14 <u>copay</u> /visit	\$14 <u>copay</u> /visit	None.
	<u>Preventive care/screening/immunization</u>	No charge.	No charge (except <u>balance billing</u>).	Age and frequency limitations may apply. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Inpatient: 20% <u>coinsurance</u> Outpatient: No charge.	Inpatient: 20% <u>coinsurance</u> Outpatient: No charge except <u>balance billing</u> .	<u>Preauthorization</u> for certain services is required to avoid nonpayment.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> for certain services is required to avoid nonpayment.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hmsa.com	Generic drugs (Tier 1)	Retail: \$7 <u>copayment</u> /script. Mail order: \$11 <u>copayment</u> /script.	Retail: \$7 copayment and 20% <u>coinsurance</u> /script. Mail order: Not covered.	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit). • One retail <u>copayment</u> for 1-30 day supply, two retail <u>copayments</u> for 31-60 day supply, and three retail <u>copayments</u> for 61-90 day supply. • One mail order <u>copayment</u> for 84-90 day supply at a 90-day at retail network or contracted mail order provider. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs (Tier 2)	Retail: \$30 <u>copayment</u> /script. Mail order: \$65 <u>copayment</u> /script.	Retail: \$30 copayment and 20% <u>coinsurance</u> /script. Mail order: Not covered.	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit). • In addition to your <u>copay</u> and/or <u>coinsurance</u>, you will be responsible for a \$45 Tier 3 Cost Share per retail copay. • Cost to you for retail Tier 3 drugs: One <u>copay</u> plus one Tier 3 Cost Share for 1-30 day supply, two <u>copays</u> plus two Tier 3 Cost Shares for 31-60 day supply, and three <u>copays</u> plus three Tier 3 Cost Shares for 61-90 day supply.

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)	
	Non-preferred brand drugs (Tier 3)	Retail: \$30 <u>copayment</u> /script. Mail order: \$65 <u>copayment</u> /script.	Retail: \$30 copayment and 20% <u>coinsurance</u> /script. Mail order: Not covered	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit). • In addition to your <u>copay</u> and/or <u>coinsurance</u>, you will be responsible for a \$135 Tier 3 Cost Share per mail order copay. • Cost to you for mail order Tier 3 drugs: One mail order <u>copay</u> plus one mail order Tier 3 Cost Share for an 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	<u>Specialty drugs</u> (Tiers 4 & 5)	Preferred Specialty: \$100 <u>copayment</u> /script. Other Brand specialty: \$200 <u>copayment</u> /script. Mail order: Not covered	Not covered	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit). • Retail benefits for <u>specialty drugs</u> limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$14 <u>copayment</u> for a covered physician visit.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$20 <u>copayment</u> /visit for a covered Physician visit in the emergency room.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<ul style="list-style-type: none"> • Ground transportation covered to the nearest adequate hospital to treat your illness or injury. • Air transportation limited to the nearest adequate hospital within the State of Hawaii.
	<u>Urgent care</u>	\$14 <u>copayment</u> /visit	\$14 <u>copayment</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$20 <u>copayment</u> for a covered physician visit.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	HMSA: Physician services: \$14 copayment/visit Other outpatient services: 20% <u>coinsurance</u> ARP: No charge	HMSA: Physician services: \$14 copayment/visit Other outpatient services: 20% <u>coinsurance</u> ARP: Not covered	Additional substance abuse benefits are available through Assistance Recovery Program (ARP).
	Inpatient services	Physician services: 20% <u>coinsurance</u> Facility: 20% <u>coinsurance</u>	HMSA: 20% <u>coinsurance</u> ARP: Not covered	<u>Preauthorization</u> by ARP is required if you are not Medicare eligible.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply to certain <u>preventive services</u>. • Depending on the type of services, <u>coinsurance</u> or <u>copayment</u> may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 150 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required to avoid a penalty of nonpayment. You pay 100% for Cardiac rehabilitation, even In-Network.
	<u>Habilitation services</u>	Not covered.	Not covered.	You pay 100% of this service, even In-Network.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 120 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required to avoid a penalty of nonpayment.
	<u>Hospice services</u>	No charge.	Not covered.	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If you elect vision coverage, it will be through a separate vision plan with Vision Service Plan (VSP).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be through a separate dental plan with Hawaii Dental Services (HDS).

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.)

- Acupuncture
- Cardiac Rehabilitation
- Cosmetic surgery
- Dental care (Adult) (child)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult) (child)
- Routine foot care
- Weight loss programs (except as required under health reform)

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

- Bariatric surgery (requires precertification)
- Chiropractic care (e.g., office visits, x-ray films – limited to services covered by this medical plan and within the scope of a chiropractor's license)
- Hearing aids (limited to one hearing aid per ear every 60 months)
- Infertility treatment (requires precertification and limited to a one time only benefit for one outpatient procedure while you are an HMSA member)
- 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/ebsa/healthreform> 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 www.HealthCare.gov or call 1-800-318-2596.

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, 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/ebsa/healthreform>. 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 plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? 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 section.*—————

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 \$0
- Specialist copayment \$14
- Hospital (facility) coinsurance 20%
- 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,420

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$14
- Hospital (facility) coinsurance 20%
- 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,060

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$14
- Hospital (facility) coinsurance 20%
- 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300