**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: |
|---|---|---|
| **What is the overall deductible?** | **$200** individual / **$600** family | 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. |
| **Are there services covered before you meet your deductible?** | Yes. Certain preventive care and well-child care services will be covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$2,200** individual / **$6,600** family (applies to medical plan coverage). **$3,600** individual / **$4,200** family (applies to prescription drug coverage). | 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. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, 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. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **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 network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Specialist visit | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | **Other practitioner office visit:** | | | |
| | Physical and Occupational Therapist | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Psychologist | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Nurse Practitioner | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Preventive care (Well Child Physician Visit) | No charge; deductible does not apply | No charge; 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 | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Immunization (Standard and Travel) | No charge; deductible does not apply | No charge; deductible does not apply | |
| **If you have a test** | **Diagnostic test** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | **X-ray** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 20% coinsurance | |

| 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** | **Blood Work** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | No charge; deductible does not apply | No charge; deductible does not apply | |
| | **Imaging** (CT/PET scans, MRIs) | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 20% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | Tier 1 - mostly Generic drugs (retail) | $7 copay/prescription; deductible does not apply | $7 copay and 20% coinsurance/prescription; deductible does not apply | One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply. |
| | Tier 1 - mostly Generic drugs (mail order) | $11 copay/prescription; deductible does not apply | Not covered | One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 2 - mostly Preferred Formulary Drugs (retail) | $30 copay/prescription; deductible does not apply | $30 copay and 20% coinsurance/prescription; deductible does not apply | One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply. |
| | Tier 2 - mostly Preferred Formulary Drugs (mail order) | $65 copay/prescription; deductible does not apply | Not covered | One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 3 - mostly Non-preferred Formulary Drugs (retail) | $30 copay/prescription; deductible does not apply | $30 copay and 20% coinsurance/prescription; deductible does not apply | In addition to your copay and/or coinsurance, you will be responsible for a **$45 Tier 3 Cost Share per retail copay.** Cost to you for retail Tier 3 drugs: One copay plus one Tier 3 Cost Share for 1-30 day supply, two copays plus two Tier 3 Cost Shares for 31-60 day supply, and three copays 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) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | Tier 3 - mostly Non-preferred Formulary Drugs (mail order) | $65 copay/prescription; deductible does not apply | Not covered | In addition to your copay and/or coinsurance, 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 copay 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. |
| | Tier 4 - mostly Preferred Formulary Specialty drugs (retail) | $100 copay/prescription; deductible does not apply | Not covered | Retail benefits for Tier 4 and Tier 5 drugs are limited to a 30-day supply. Available in participating Specialty Pharmacies only. |
| | Tier 5 - mostly Non-preferred Formulary Specialty drugs (retail) | $200 copay/prescription; deductible does not apply | Not covered | |
| | Tier 4 & 5 (mail order) | Not covered | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | ---none--- |
| | Physician Visits | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Surgeon fees | 20% coinsurance (cutting) | 20% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 20% coinsurance (non-cutting) | ---none--- |
| **If you need immediate medical attention** | **Emergency room care** | | | |
| | Physician Visit | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Emergency room | 20% coinsurance | 20% coinsurance | ---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. |

| 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 immediate medical attention** | Emergency medical transportation (ground) | 20% coinsurance | 20% coinsurance | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | Urgent care | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | ---none--- |
| | Physician Visits | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Surgeon fee | 20% coinsurance (cutting) | 20% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 20% coinsurance (non-cutting) | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | **Outpatient services** | | | |
| | Physician services | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | ---none--- |
| | Hospital and facility services | No charge; deductible does not apply | No charge; deductible does not apply | ---none--- |
| | **Inpatient services** | | | |
| | Physician services | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | ---none--- |
| | Hospital and facility services | 20% coinsurance | 20% coinsurance | ---none--- |
| **If you are pregnant** | Office visit (Prenatal and postnatal care) | No charge; deductible does not apply | No charge; deductible does not apply | 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 | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | 150 Visits per Calendar Year |
| | Rehabilitation services | $12 copay/visit; deductible does not apply | $12 copay/visit; deductible does not apply | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |

| 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 help recovering or have other special health needs** | Skilled nursing care | 20% coinsurance | 20% 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 | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Hospice services | No charge; deductible does not apply | No charge; deductible does not apply | ---none--- |
| **If your child needs dental or eye care** | Children's eye exam | $10 copay/exam; deductible does not apply | 50% coinsurance; deductible does not apply | Limited to one routine vision exam per calendar year. |
| | Children's glasses (single vision lenses and frames selected within designated group) | $25 copay/glasses; deductible does not apply | 50% coinsurance; deductible does not apply | The frequency in which you can obtain a pair of glasses may vary |
| | 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.)**

- Cardiac rehabilitation
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Long-term care
- Private-duty nursing
- 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.)**

- Acupuncture
- Bariatric surgery
- 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 (Artificial Insemination and In Vitro Fertilization. Please refer to your plan document for limitations and additional details)
- Non-emergency care when traveling outside the U.S. For more information, see www.hmsa.com
- Routine eye care (Adult) (limited to services covered under a rider)

**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.

**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, kwiijigo 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 | $200 |
| Specialist copayment | $12 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialistoffice visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests(*ultrasounds and blood work*)
Specialist visit(*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $20 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,680** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $12 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physicianoffice visits (*including disease education*)
Diagnostic tests(*blood work*)
Prescription drugs
Durable medical equipment(*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$620** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $12 |
| 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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

The plan would be responsible for the other costs of these EXAMPLE covered services.