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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible. You do not have to meet a deductible amount before the plan pays for any services.
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?	**$2,500** individual / **$7,500** family.	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, 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.

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 copay/visit	$14 copay/visit	---none---
	Specialist visit	$14 copay/visit	$14 copay/visit	---none---
	Other practitioner office visit:			
	Physical and Occupational Therapist	20% coinsurance	20% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Psychologist	$14 copay/visit	$14 copay/visit	---none---
	Nurse Practitioner	$14 copay/visit	$14 copay/visit	---none---
	Preventive care (Well Child Physician Visit)	No charge	No charge	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	No charge	
	Immunization (Standard and Travel)	No charge	No charge	
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	20% coinsurance	
	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	
	Blood Work			
	Inpatient	20% coinsurance	20% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	No charge	No charge	
	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	

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.	**Generic drugs (retail)**			
	Contraceptives – Oral & Other Methods	No charge	No charge	Retail benefits limited to a 30-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	No charge	
	Diabetic Drugs	20% coinsurance	20% coinsurance	
	Insulin	20% coinsurance	20% coinsurance	
	Oral Chemotherapy	No charge	No charge	
	Over the Counter Contraceptives	No charge	No charge	
	USPSTF Recommended Drugs	No charge	No charge	
	Generic drugs (mail order)			
	Contraceptives – Oral & Other Methods	No charge	Not covered	Mail order benefits limited to a 90-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	Not covered	
	Diabetic Drugs	20% coinsurance	Not covered	
	Insulin	20% coinsurance	Not covered	
	Oral Chemotherapy	No charge	Not covered	
	Over the Counter Contraceptives	No charge	Not covered	
	USPSTF Recommended Drugs	No charge	Not covered	
	Preferred Formulary Drugs (retail)			
	Contraceptives – Oral & Other Methods	20% coinsurance	20% coinsurance	Retail benefits limited to a 30-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	No charge	
	Diabetic Drugs	20% coinsurance	20% coinsurance	
	Diabetic Supplies	No charge	No charge	
	Insulin	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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hmsa.com.	Oral Chemotherapy	No charge	No charge	
	Over the Counter Contraceptives	No charge	No charge	
	USPSTF Recommended Drugs	No charge	No charge	
	Preferred Formulary Drugs (mail order)			
	Contraceptives – Oral & Other Methods	20% coinsurance	Not covered	Mail order benefits limited to a 90-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	Not covered	
	Diabetic Drugs	20% coinsurance	Not covered	
	Diabetic Supplies	No charge	Not covered	
	Insulin	20% coinsurance	Not covered	
	Oral Chemotherapy	No charge	Not covered	
	Over the Counter Contraceptives	No charge	Not covered	
	USPSTF Recommended Drugs	No charge	Not covered	
	Non-preferred Formulary Drugs (retail)			
	Contraceptives – Oral & Other Methods	30% coinsurance	30% coinsurance	Retail benefits limited to a 30-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	No charge	
	Diabetic Drugs	30% coinsurance	30% coinsurance	
	Diabetic Supplies	20% coinsurance	20% coinsurance	
	Insulin	30% coinsurance	30% coinsurance	
	Oral Chemotherapy	No charge	No charge	
	Over the Counter Contraceptives	No charge	No charge	
	USPSTF Recommended Drugs	No charge	No charge	

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.	**Non-preferred Formulary Drugs (mail order)**			
	Contraceptives – Oral & Other Methods	30% coinsurance	Not covered	Mail order benefits limited to a 90-day supply Contraceptives may be covered up to a 12-month supply Over the counter contraceptives are available by prescription only
	Contraceptives – Diaphragms/ Cervical Caps	No charge	Not covered	
	Diabetic Drugs	30% coinsurance	Not covered	
	Diabetic Supplies	20% coinsurance	Not covered	
	Insulin	30% coinsurance	Not covered	
	Oral Chemotherapy	No charge	Not covered	
	Over the Counter Contraceptives	No charge	Not covered	
	USPSTF Recommended Drugs	No charge	Not covered	
	Specialty drugs	20% coinsurance	20% coinsurance	Limited to outpatient injectable drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	---none---
	Physician Visits	$14 copay/visit	$14 copay/visit	---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	$20 copay/visit	$20 copay/visit	---none---
	Emergency room	$100 copay/visit	$100 copay/visit	---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	20% coinsurance	Ground transportation to the nearest, adequate hospital to treat your illness or injury.

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)	
	Urgent care	$14 copay/visit	$14 copay/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	---none---
	Physician Visits	$20 copay/visit	$20 copay/visit	---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	$14 copay/visit	$14 copay/visit	---none---
	Hospital and facility services	20% coinsurance	20% coinsurance	---none---
	Inpatient services			
	Physician services	No charge	No charge	---none---
	Hospital and facility services	20% coinsurance	20% coinsurance	---none---
If you are pregnant	Office visit (Prenatal and postnatal care)	10% coinsurance	10% 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	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% 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	20% coinsurance	20% 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	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.

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	No charge	---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.)

- Acupuncture
- Cardiac rehabilitation
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Long-term care
- 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.)

- 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

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 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	$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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,790**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$400
The total Joe would pay is	**$1,300**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$510**

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