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-glossayr/ 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 covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Yes. $2,500 individual / $7,500 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. For alcoholism or chemical dependency providers, call the Assistance Recovery Program (ARP) at (800) 562-3277.	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.

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	$14 copay/visit	$14 copay/visit	None.
	Specialist visit	$14 copay/visit	$14 copay/visit	None.
	Preventive care/screening/ Immunization	No charge.	No charge (except balance billing).	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.
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: 20% coinsurance Outpatient: No charge.	Inpatient: 20% coinsurance Outpatient: No charge except balance billing.	Preauthorization for certain services is required to avoid nonpayment.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Preauthorization for certain services is required to avoid nonpayment.

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 (Tier 1)	Retail: $7 copayment/script. Mail order: $11 copayment/script.	Retail: $7 copayment and 20% coinsurance/script. Mail order: Not covered.	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • One retail copayment for 1-30 day supply, two retail copayments for 31-60 day supply, and three retail copayments for 61-90 day supply. • One mail order copayment 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 copayment/script. Mail order: $65 copayment/script.	Retail: $30 copayment and 20% coinsurance/script. Mail order: Not covered.	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • 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.
	Non-preferred brand drugs (Tier 3)	Retail: $30 copayment/script. Mail order: $65 copayment/script.	Retail: $30 copayment and 20% coinsurance/script. Mail order: Not covered	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • 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.
	Specialty drugs (Tiers 4 & 5)	Preferred Specialty: $100 copayment/script. Other Brand specialty: $200 copayment/script. Mail order: Not covered	Not covered	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Retail benefits for specialty drugs limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	$14 copayment 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 immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$20 copayment/visit for a covered Physician visit in the emergency room.
	Emergency medical transportation	20% coinsurance	20% coinsurance	• 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.
	Urgent care	$14 copayment/visit	$14 copayment/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	$20 copayment for a covered physician visit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician services: $14 copayment/visit Other outpatient services: 20% coinsurance	Physician services: $14 copayment/visit Other outpatient services: 20% coinsurance	None.
	Inpatient services	Physician services: 20% coinsurance Facility: 20% coinsurance	20% coinsurance	None.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	• Cost sharing does not apply to certain preventive services. • Depending on the type of services, coinsurance or copayment may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	20% 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 need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 150 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Preauthorization is required to avoid a penalty of nonpayment. You pay 100% for Cardiac rehabilitation, even In-Network.
	Habilitation services	Not covered.	Not covered.	You pay 100% of this service, even In-Network.
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required to avoid a penalty of nonpayment.
	Hospice services	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, 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	$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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$2,300
What isn't covered	
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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$300
What isn't covered	
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

In this example, Mia would pay:

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

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