# HMSA: EUTF 90/10

**Coverage Period: 07/01/2016 - 06/30/2017**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual / Family | **Plan Type: PPO**

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.hmsa.com or by calling 1-800-776-4672.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | **$0** for Participating providers **$100** person/**$300** family for Non-participating providers. Doesn't apply to contraceptives, emergency services, prescription drugs and supplies, preventive care and well-child care. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| Are there other deductibles for specific services? | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out–of–pocket limit on my expenses? | Yes. **$2,000** person/**$4,000** family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out–of–pocket limit? | Premiums, balance-billed charges, prescription drug copayments, payments for services that exceed a benefit maximum, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of participating providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a specialist? | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**. |

**The HMSA plans do not include prescription drug coverage. Please see the CVS Caremark SBC for information regarding the prescription drug coverage.**

**Questions**: Call **1-800-776-4672** or visit us at http://www.hmsa.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.hmsa.com/sbc or call **1-800-776-4672** to request a copy. For TTY assistance, call **711**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% co-insurance | 30% co-insurance | ---none--- |
| | Specialist visit | 10% co-insurance | 30% co-insurance | ---none--- |
| | **Other practitioner office visit:** Physical and Occupational Therapist | 10% co-insurance | 30% co-insurance | Services may require precertification. Benefits may be denied if precertification is not obtained. |
| | Psychologist | 10% co-insurance | 30% co-insurance | ---none--- |
| | Nurse Practitioner | 10% co-insurance | 30% co-insurance | ---none--- |
| | **Preventive care** (Well Child Physician Visit) | No charge | 30% co-insurance | Age and frequency limitations may apply. |
| | **Screening** (Grade A & B recommendations of the U.S. Preventive Services Task Force) | No charge | 30% co-insurance | ---none--- |
| | **Immunization** (Standard and Travel) | No charge | No charge | ---none--- |
| **If you have a test** | **Diagnostic test** | | | Services may require precertification. |
| | Inpatient | 10% co-insurance | 30% co-insurance | Benefits may be denied if |
| | Outpatient | 10% co-insurance | 30% co-insurance | precertification is not obtained. |
| | **X-ray** | | | Services may require precertification. |
| | Inpatient | 10% co-insurance | 30% co-insurance | Benefits may be denied if |
| | Outpatient | 10% co-insurance | 30% co-insurance | precertification is not obtained. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| If you have a test | **Blood Work** | | | Services may require precertification. |
| | Inpatient | 10% co-insurance | 30% co-insurance | Benefits may be denied if |
| | Outpatient | 10% co-insurance | 30% co-insurance | precertification is not obtained. |
| | **Imaging (CT/PET scans, MRIs)** | | | Services may require precertification. |
| | Inpatient | 10% co-insurance | 30% co-insurance | Benefits may be denied if |
| | Outpatient | 10% co-insurance | 30% co-insurance | precertification is not obtained. |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at http://www.hmsa.com. | **Generic drugs (retail)** | | | |
| | Contraceptives – Oral & Other Methods | No charge | 20% co-insurance | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | $10 copay/prescription | |
| | Diabetic Drugs | 20% co-insurance | 20% co-insurance | Retail benefits limited to a 30-day supply |
| | Insulin | 20% co-insurance | 20% co-insurance | |
| | Oral Chemotherapy | No charge | No charge | |
| | Over the Counter Contraceptives | No charge | 20% co-insurance | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | 20% co-insurance | |
| | **Generic drugs (mail order)** | | | |
| | Contraceptives – Oral & Other Methods | No charge | Not covered | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | Not covered | Mail order benefits limited to a 90-day supply |
| | Diabetic Drugs | 20% co-insurance | Not covered | |
| | Insulin | 20% co-insurance | Not covered | |
| | Oral Chemotherapy | No charge | Not covered | |
| | Over the Counter Contraceptives | No charge | Not covered | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | Not covered | |

**The HMSA plans do not include prescription drug coverage. Please see the CVS Caremark SBC for information regarding the prescription drug coverage.**

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at http://www.hmsa.com. | **Preferred brand drugs (retail)** | | | |
| | Contraceptives – Oral & Other Methods | 20% co-insurance | 20% co-insurance | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | $10 copay/prescription | |
| | Diabetic Drugs | 20% co-insurance | 20% co-insurance | Retail benefits limited to a 30-day supply |
| | Diabetic Supplies | No charge | No charge | |
| | Insulin | 20% co-insurance | 20% co-insurance | |
| | Oral Chemotherapy | No charge | No charge | |
| | Over the Counter Contraceptives | No charge | 20% co-insurance | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | 20% co-insurance | |
| | **Preferred brand drugs (mail order)** | | | |
| | Contraceptives – Oral & Other Methods | 20% co-insurance | Not covered | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | Not covered | Mail order benefits limited to a 90-day supply |
| | Diabetic Drugs | 20% co-insurance | Not covered | |
| | Diabetic Supplies | No charge | Not covered | |
| | Insulin | 20% co-insurance | Not covered | |
| | Oral Chemotherapy | No charge | Not covered | |
| | Over the Counter Contraceptives | No charge | Not covered | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | Not covered | |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at http://www.hmsa.com. | **Non-preferred brand drugs (retail)** | | | |
| | Contraceptives – Oral & Other Methods | 30% co-insurance | 30% co-insurance | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | $10 copay/prescription | Retail benefits limited to a 30-day supply |
| | Diabetic Drugs | 30% co-insurance | 30% co-insurance | |
| | Diabetic Supplies | 20% co-insurance | 20% co-insurance | |
| | Insulin | 30% co-insurance | 30% co-insurance | |
| | Oral Chemotherapy | No charge | No charge | |
| | Over the Counter Contraceptives | No charge | 20% co-insurance | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | 20% co-insurance | |
| | **Non-preferred brand drugs (mail order)** | | | |
| | Contraceptives – Oral & Other Methods | 30% co-insurance | Not covered | |
| | Contraceptives – Diaphragms/ Cervical Caps | No charge | Not covered | Mail order benefits limited to a 90-day supply |
| | Diabetic Drugs | 30% co-insurance | Not covered | |
| | Diabetic Supplies | 20% co-insurance | Not covered | |
| | Insulin | 30% co-insurance | Not covered | |
| | Oral Chemotherapy | No charge | Not covered | |
| | Over the Counter Contraceptives | No charge | Not covered | Over the counter contraceptives are available by prescription only. |
| | USPSTF Recommended Drugs | No charge | Not covered | |
| | Specialty drugs | 10% co-insurance | 30% co-insurance | Limited to outpatient injectable drugs |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% co-insurance | 30% co-insurance | ---none--- |
| | Physician Visit | 10% co-insurance | 30% co-insurance | ---none--- |
| | Surgeon fees | 10% co-insurance (cutting)<br>10% co-insurance (non-cutting) | 30% co-insurance (cutting)<br>30% co-insurance (non-cutting) | ---none---<br>---none--- |

**The HMSA plans do not include prescription drug coverage. Please see the CVS Caremark SBC for information regarding the prescription drug coverage.**

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| If you need immediate medical attention | **Emergency room services** | | | |
| | Physician Visit | 10% co-insurance | 10% co-insurance | ---none--- |
| | Emergency Room | 10% co-insurance | 10% co-insurance | ---none--- |
| | Emergency medical transportation (air) | 10% co-insurance | 30% co-insurance | Limited to air transport to the nearest adequate hospital within the State of Hawaii. |
| | Emergency medical transportation (ground) | 10% co-insurance | 30% co-insurance | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | Urgent care | 10% co-insurance | 30% co-insurance | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% co-insurance | 30% co-insurance | 365 Days per Calendar Year |
| | Physician Visit | 10% co-insurance | 30% co-insurance | ---none--- |
| | Surgeon fee | 10% co-insurance (cutting)<br>10% co-insurance (non-cutting) | 30% co-insurance (cutting)<br>30% co-insurance (non-cutting) | ---none---<br>---none--- |
| If you have mental health, behavioral health, or substance abuse needs | **Mental/Behavioral health outpatient services** | | | |
| | Physician services | 10% co-insurance | 30% co-insurance | ---none--- |
| | Hospital and facility services | 10% co-insurance | 30% co-insurance | ---none--- |
| | **Mental/Behavioral health inpatient services** | | | |
| | Physician services | 10% co-insurance | 30% co-insurance | ---none--- |
| | Hospital and facility services | 10% co-insurance | 30% co-insurance | ---none--- |
| | **Substance use disorder outpatient services** | | | |
| | Physician services | 10% co-insurance | 30% co-insurance | ---none--- |
| | Hospital and facility services | 10% co-insurance | 30% co-insurance | ---none--- |
| | **Substance use disorder inpatient services** | | | |
| | Physician services | 10% co-insurance | 30% co-insurance | ---none--- |
| | Hospital and facility services | 10% co-insurance | 30% co-insurance | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you are pregnant** | Prenatal and postnatal care | 10% co-insurance | 30% co-insurance | ---none--- |
| | Delivery (surgery) | 10% co-insurance | 30% co-insurance | ---none--- |
| | Inpatient services (hospital room and board) | 10% co-insurance | 30% co-insurance | 365 Days per Calendar Year |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 30% co-insurance | 150 Services/Visits per Calendar Year |
| | Rehabilitation services | 10% co-insurance | 30% co-insurance | Services may require precertification. Benefits may be denied if precertification is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |
| | Skilled nursing care | 10% co-insurance | 30% co-insurance | 120 Days per Calendar Year |
| | Durable medical equipment | 10% co-insurance | 30% co-insurance | Services may require precertification. Benefits may be denied if precertification is not obtained. |
| | Hospice service | No charge | Not covered | ---none--- |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | Excluded service |
| | Glasses (single vision lenses and frames selected within designated group) | Not covered | Not covered | Excluded service |
| | Dental check-up | Not covered | Not covered | Excluded service |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cardiac rehabilitation
- Chiropractic care (e.g. hot/cold application, laser therapy)
- 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** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires precertification)
- 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 http://www.hmsa.com

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-776-4672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

All benefits are subject to the definitions, limitations, and exclusions set forth in the Guide to Benefits (GTB). If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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/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.

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.

If you disagree with our appeals decision and coverage is insured (i.e. fully insured) you must request review by an Independent Review Organization (IRO) selected by 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. If coverage is self-funded, you must request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs. Send written requests to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii, 96805-1958.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## 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:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,570**
- **Patient pays: $970**

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $100 |
| Co-pays | $0 |
| Co-insurance | $720 |
| Limits or exclusions | $150 |
| **Total** | **$970** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $4,420**
- **Patient pays: $980**

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $100 |
| Co-pays | $0 |
| Co-insurance | $800 |
| Limits or exclusions | $80 |
| **Total** | **$980** |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-776-4672.

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.