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?	For network providers **$0** For out-of-network providers **$100** individual / **$300** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay in a calendar year. 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. All services received from a participating or in-network provider 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.
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?	Medical: **$2,000** individual / **$4,000** family Drug: **$4,350** individual / **$8,700** family Specialty Drug: **$2,500** individual	The out-of-pocket limit is the most you could pay in a calendar 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 www.hmsa.com/search/providers or call 1-800-776-4672 for a list of network providers. For a list of in-network retail pharmacies, see www.caremark.com or call 1-855-801-8263.	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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	---none---
	Specialist visit	10% coinsurance	30% coinsurance	---none---
	Preventive care / Screening	No charge	30% coinsurance; deductible does not apply for well child physician visit	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.
	Immunization (standard and travel)	No charge	No charge; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (30/60/90-day supply)	**Retail:** $5/$10/$15 copayment **Retail 90/Mail:** $5/$10/$10 copayment	**Retail:** $5/$10/$15 copayment + 20% coinsurance **Mail:** Not covered	• Deductible does not apply for outpatient prescription drugs. • A 90-day supply for maintenance medications is required after three initial 30-day supply fills. • Some prescriptions are subject to preapproval, quantity limits and/or step therapy requirements. • Penalties for failure to obtain precertification of drugs or dispense as written (DAW) specifications do not count toward the out-of-pocket limit. • Certain preventive care drugs mandated by Health Reform are payable at no charge with a prescription.
	Preferred brand drugs (30/60/90-day supply)	**Retail:** $25/$50/$75 copayment **Retail 90/Mail:** $25/$50/$50 copayment	**Retail:** $25/$50/$75 copayment + 20% coinsurance **Mail:** Not covered	
	Non-preferred brand drugs (30/60/90-day supply)	**Retail:** $50/$100/$150 copayment **Retail 90/ Mail:** $50/$100/$100 copayment	**Retail:** $50/$100/$150 copayment + 20% coinsurance **Mail:** Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.hmsa.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Specialty drugs (30-day supply only)	**Retail:** Generic: 10% coinsurance up to $200 per fill Preferred brand: 20% coinsurance up to $300 per fill Non-preferred brand: 30% coinsurance up to $400 per fill **Mail:** Not covered	**Retail:** Generic: 10% coinsurance up to $200 per fill Preferred brand: 20% coinsurance up to $300 per fill Non-preferred brand: 30% coinsurance up to $400 per fill **Mail:** Not covered	Specialty drugs have a $2,500 per individual out-of-pocket limit per calendar year and is counted toward the total annual drug out-of-pocket limit. To find a specialty network pharmacy, call 1-855-801-8263.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	30% coinsurance	---none---
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance; deductible does not apply	---none---
	Emergency medical transportation (air or ground)	10% coinsurance	10% coinsurance; deductible does not apply (air) 30% coinsurance (ground)	Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental U.S. is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply. Ground transportation to the nearest adequate hospital to treat your illness or injury.
	Urgent care	10% coinsurance	30% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	30% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	---none---
	Inpatient services	10% coinsurance	30% coinsurance	---none---

* For more information about limitations and exceptions, see the plan or policy document at www.hmsa.com.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits (prenatal and postnatal care)	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	150 Visits per Calendar Year
	Rehabilitation services	10% coinsurance	30% 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	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Hospice services	No charge	Not covered	---none---
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Provided under a separate vision plan.
	Children's glasses	Not covered	Not covered	Provided under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	Provided under a separate dental plan.

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 (except as required by Health Reform Law)

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

- Bariatric surgery
- Chiropractic care (limited to 20 visits/calendar year from American Specialty Health Network)
- 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/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 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.

For prescription drug appeals you may send your written request to: CVS Caremark Appeals Department MC, P.O. Box 52084, Phoenix, AZ 85072-2084 or fax to 1-866-433-1172 attention – Appeals Dept. For specialty drug appeals, you may send your written request to: CVS Caremark Specialty Guideline Mgmt Appeals Department, 800 Biermann Court, Ste. B, Mt. Prospect, IL 60056 or fax to 1-855-230-5548 attention – Appeals Dept. If you have any questions about prescription drug appeals, you may call CVS Customer Care toll-free at 1-855-801-8263, TDD 711.

* For more information about limitations and exceptions, see the plan or policy document at www.hmsa.com.

Does this plan 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 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 coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$10
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,370**

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 coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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

The plan's overall deductible	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$310**

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

* For more information about limitations and exceptions, see the plan or policy document at www.hmsa.com.