HMSA: MED X-T/DRG 496/VIS 0CK/DEN L50

Coverage Period: 01/01/2014 - 12/31/2014

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

Coverage for: All Coverage Tiers | **Plan Type: HMO**

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**	See the chart starting on page 2 for your costs for services this plan covers.
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. **$2,500** person/**$7,500** 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 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**.
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?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **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	$15 copay/visit	Not covered	---none---
	Specialist visit	$15 copay/visit	Not covered	---none---
	Other practitioner office visit: Physical and Occupational Therapist	$15 copay/visit	Not covered	Services may require precertification.
	Psychologist	$15 copay/visit	Not covered	---none---
	Nurse Practitioner	$15 copay/visit	Not covered	---none---
	Preventive care (Well Child Physician Visit)	No charge	Not covered	Age and frequency limitations may apply.
	Screening Colonoscopy Screening	No charge	Not covered	---none---
	Mammography Screening	No charge	Not covered	For age 35 to 39, limited to one screening. For age 40 and over, limited to one screening per calendar year.
	Pap Smears Screening	No charge	Not covered	Limited to one per calendar year.
	Prostate Specific Antigen Test Screening	10% co-insurance	Not covered	---none---
	Sigmoidoscopy Screening	No charge	Not covered	---none---
	Immunization (Standard)	No charge	Not covered	---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 have a test	**Diagnostic test** Inpatient Outpatient	 No charge 10% co-insurance	 Not covered Not covered	Services may require precertification.
	X-ray Inpatient Outpatient	 No charge 10% co-insurance	 Not covered Not covered	Services may require precertification.
	Blood Work Inpatient Outpatient	 No charge 10% co-insurance	 Not covered Not covered	Services may require precertification.
	Imaging (CT/PET scans, MRIs) Inpatient Outpatient	 No charge 10% co-insurance	 Not covered Not covered	Services may require precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.hmsa.com.	Generic drugs (retail)	$7 copay/prescription	$7 copay and 20% co-insurance/prescription	Retail benefits limited to a 30-day supply
	Generic drugs (mail order)	$11 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply
	Preferred brand drugs (retail)	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	Retail benefits limited to a 30-day supply
	Preferred brand drugs (mail order)	$65 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply
	Non-preferred brand drugs (retail)	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	Retail benefits limited to a 30-day supply
	Non-preferred brand drugs (mail order)	$65 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply Other Brand Cost Share of $35 also applies at retail and $105 at mail order.
	Specialty drugs (retail)	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	Retail benefits limited to a 30-day supply

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 More information about **prescription drug coverage** is available at http://www.hmsa.com.	Specialty drugs (mail order)	$65 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply Other Brand Cost Share of $35 also applies at retail and $105 at mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	---none---
	Physician Visit	$15 copay/visit	Not covered	---none---
	Surgeon fees	$15 copay (cutting) $15 copay (non-cutting)	Not covered Not covered	---none--- ---none---
If you need immediate medical attention	**Emergency room services** Physician Visit	No charge	No charge	---none---
	Emergency Room	$75 copay/visit	$75 copay/visit	---none---
	Emergency medical transportation (air)	20% co-insurance	Not covered	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	Emergency medical transportation (ground)	20% co-insurance	Not covered	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	$15 copay/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copay/day	Not covered	---none---
	Physician Visit	No charge	Not covered	---none---
	Surgeon fee	No charge (cutting) No charge (non-cutting)	Not covered Not covered	---none--- ---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 have mental health, behavioral health, or substance abuse needs	**Mental/Behavioral health outpatient services**			
	Physician services	$15 copay/visit	Not covered	---none---
	Hospital and facility services	No charge	Not covered	---none---
	Mental/Behavioral health inpatient services			
	Physician services	No charge	Not covered	---none---
	Hospital and facility services	$75 copay/day	Not covered	---none---
	Substance use disorder outpatient services			
	Physician services	$15 copay/visit	Not covered	---none---
	Hospital and facility services	No charge	Not covered	---none---
	Substance use disorder inpatient services			
	Physician services	No charge	Not covered	---none---
	Hospital and facility services	$75 copay/day	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	---none---
	Delivery (surgery)	No charge	Not covered	---none---
	Inpatient services (hospital room and board)	$75 copay/day	Not covered	---none---
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	365 Visits per illness/injury
	Rehabilitation services	$15 copay/visit	Not covered	Services may require precertification. Excludes cardiac rehabilitation.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	No charge	Not covered	60 Days per Benefit Period
	Durable medical equipment	50% co-insurance	Not covered	Services may require precertification.
	Hospice service	No charge	Not covered	---none---
If your child needs dental or eye care	Eye exam	$15 copay/exam	Not covered	Limited to one routine vision exam per calendar year.

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 your child needs dental or eye care	Glasses (single vision lenses and frames selected within designated group)	$25 copay/glasses	All charges less $28 plan payment	The frequency in which you can obtain a pair of glasses may vary
	Dental check-up	No charge	Not covered	2 Services/Visits per Calendar Year

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
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances
- Cardiac rehabilitation
- Chiropractic care
- Cosmetic surgery
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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)
- Dental care (Adult) (limited to services covered under a rider)
- 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)
- Private-duty nursing
- Routine eye care (Adult)

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:

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: $7,230**
- **Patient pays: $310**

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	$0
Co-pays	$90
Co-insurance	$70
Limits or exclusions	$150
Total	**$310**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $4,240**
- **Patient pays: $1,160**

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	$0
Co-pays	$430
Co-insurance	$650
Limits or exclusions	$80
Total	**$1,160**

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.